Supreme Court, U.S.
FILED
JUN 11 1998
OFFICE OF THE CLERK

No. 97 2030

In The

Supreme Court of the United States

October Term, 1997

SCHOOL DISTRICT OF PHILADELPHIA,

Petitioner,

vs.

DELORES SCOTT SULLIVAN, *et al.*,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Third Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Sections 306 (f.1)(5) and (6) of the Pennsylvania Workers' Compensation Act, 77 Pa. Stat. Ann. §§ 531(5) and (6) (West Supp. 1998), allow Pennsylvania self-insured employers and Pennsylvania insurers to delay payment of challenged medical treatment pending a utilization review to determine the reasonableness and necessity of the specific treatment questioned. The questions presented are:

1. Whether self-insured employers become "state actors" for purposes of the Due Process Clause when a state-authorized utilization review procedure is utilized.

2. Whether self-insured employers are required, under the Due Process Clause, to pay disputed medical bills prior to a determination that the medical treatment is reasonable and necessary.

3. Whether an injured worker's choice of treatment constitutes a property interest protected under the Due Process Clause of the Fourteenth Amendment.

STATEMENT OF THE PARTIES TO THE PROCEEDINGS

Petitioner states, pursuant to Rule 14.1(b), that in addition to the School District of Philadelphia, defendant/respondents in the court below included:

ROBERT BARNETT, Secretary of Labor and Industry for the Commonwealth of Pennsylvania; JOHNNY BUTLER, Secretary of Labor and Industry for the Commonwealth of Pennsylvania; RICHARD A. HIMLER, Director of the Pennsylvania Bureau of Workers' Compensation; FRANK BEAL, Director of the Pennsylvania Bureau of Workers' Compensation; CONSTANCE B. FOSTER, Insurance Commissioner for the Commonwealth of Pennsylvania; CATHERINE BAKER KNOLL, Treasurer, Commonwealth of Pennsylvania; JOHN P. O'MALLEY, Director, State Workers' Insurance Fund; AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY; INSURANCE CO. OF NORTH AMERICA; COMMERCIAL UNION INSURANCE COMPANY; CONTINENTAL CASUALTY COMPANY; DONEGAL MUTUAL INSURANCE COMPANY; HARTFORD INSURANCE COMPANY; USF&G INSURANCE COMPANY; ZURICH INSURANCE COMPANY.

The individual and organizational plaintiffs are, respectively:

DELORES SCOTT SULLIVAN; WILLIAM BATTLE; LOUIS BAUMGARTNER; ANTHONY CANCILA; CHRISTOPHER COSTELLO; WILLIAM C. DILLON, By His Guardian and Next Friend; PAULINE DILLON; TERRENCE ERVINE; CHARLES MATTHEWS; LISA LEX; SUSAN HANSEN; PHILADELPHIA AREA PROJECT ON OCCUPATIONAL SAFETY AND HEALTH; PHILADELPHIA FEDERATION OF TEACHERS.

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The School District of Philadelphia, a Pennsylvania self-insured employer, respectfully cross-petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Third Circuit in this case. This independent petition cross-references the petition for a writ of certiorari filed June 11, 1998 by eight private workers' compensation insurance companies captioned *American Mfrs. Mut. Ins. Co., et al. v. Delores Scott Sullivan, et al.*

OPINIONS BELOW

The opinion of the court of appeals (App., 4a-48a) is reported at 139 F.2d 158. The January 24, 1996 opinion of the district court granting the motion to dismiss of the private insurers for lack of state action (App., 79a-104a), is reported at 913 F. Supp. 895. The November 7, 1996 opinion of the district court holding that the statute in question does not violate due process requirements (App., 50a-74a) is not reported. The March 8, 1996 opinion of the district court denying plaintiffs' motion for final order under Fed. R. Civ. P. 54(b) (App., 76a-79a) is not reported.

STATEMENT OF JURISDICTION

The court of appeals entered its judgment on March 13, 1998 (App., 1a-3a). The jurisdiction of this court is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Fourteenth Amendment to the United States Constitution provides, in part, that "[n]o State shall . . . deprive any person of life, liberty, or property, without due process of law." The pertinent provisions of the Pennsylvania Workers'

Compensation Act, 77 Pa. Stat. Ann. § 1 *et seq.* (1992 & West Supp. 1995, 1998), are set forth at App. 107a-134a. Relevant regulations are set forth at App. 135a-137.

STATEMENT OF THE CASE

The School District of Philadelphia adopts and incorporates herein by reference the "statement" contained in the petition for a writ of certiorari filed June 11, 1998 by the private insurers captioned *American Mfrs. Mut. Ins. Co., et al., v. Delores Scott Sullivan, et al.*

The identified compelling need for cost-containment initiatives pertains equally to self-insured employers and private insurers in Pennsylvania. The Pennsylvania Workers' Compensation Act allows an employer to either insure or self-insure liability under the Act. When insured, the insurer merely "assume[s] the employer's liability [t]hereunder and shall be entitled to all of the employer's immunities and protection. . . ." 77 Pa. Stat. Ann. § 501 (West Supp. 1998), App. 107a-110a. The benefits and procedures contained in the utilization review process apply equally to Pennsylvania insurers and self-insured employers. 77 Pa. Stat. Ann. § 531(5)-(6).[1]

Prior to the enactment of the medical cost containment provisions of Act 44 in 1993, and the legislative refinement of the process in 1996 under Act 57, Pennsylvania employers and insurers were required to pay all medical bills that a physician or other practitioner of the healing arts submitted with a report

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1. Section 306 of the Pennsylvania Workers' Compensation Act, 77 Pa. Stat. Ann. § 531, was amended in 1993 (Act 44) and 1996 (Act 57). The section as it appeared before the Act 44 revision is contained in the Appendix at 111a-114a. Section 306(f.1), as amended by Act 44, appears in the Appendix at 115a-122a. Section 306(f.1), as amended by Act 57, appears in the Appendix at 123a-131a.

until such time as a workers' compensation referee (later defined "workers' compensation judge") ruled upon any challenge to that treatment. 77 Pa. Stat. Ann. § 531(2)(ii), App. 112a. Moreover, employers were required to have a reasonable basis to contest benefits before filing petitions to challenge injured employees' entitlement to receipt of the benefits, 77 Pa. Stat. Ann. § 996, App. 132a;[2] and the Act expressly prohibited the workers' compensation referees from granting a supersedeas or stay of the payment of medical bills while a challenge of treatment was pending review. 77 Pa. Stat. Ann. § 531(2)(ii).

If an employer or insurer were to prevail on a review petition, the Supersedeas Fund, created by annual assessments on Pennsylvania employers and insurers, was available for reimbursement. *Insurance Co. of N. Am. v. Workmen's Compensation Appeal Bd. (Kline & Packard Press)*, 586 A.2d 500 (Pa. Cmwlth. 1991), *aff'd*, 619 A.2d 1356 (Pa. 1993); *Pennsylvania Macaroni Co., Inc. v. Workmen's Compensation Appeal Board*, 387 A.2d 949 (Pa. Cmwlth. 1978). However, the Supersedeas Fund only reimbursed the value of those medical bills (without interest) which were paid after filing a review petition challenging the reasonableness and necessity of treatment. 77 Pa. Stat. Ann. §§ 531(2)(ii) and 999(a), App. 135a. *See, e.g., Laundry Owners Mut. Liab. Ins. Ass'n. (Stop-N-Go Food Stores) v. Workmen's Compensation Appeal Board (Herpak)*, 617 A.2d 860 (Pa. Cmwlth. 1992), *aff'd*, 644 A.2d 697 (Pa. 1994) (recognizing that medical expenses, but not interest, can be reimbursed by the Supersedeas Fund for payments made pending final outcome of the case).

Accordingly, employers found that even their own proportionate share of funds paid into the Supersedeas Fund

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2. *Werz v. Workmen's Compensation Appeal Board (Dep't. of Corrections)*, 683 A.2d 1287 (Pa. Cmwlth. 1996), *appeal denied*, 690 A.2d 1165 (Pa. 1997). Employers remain obligated to maintain a reasonable contest under Act 44 and 57, as well. 77 Pa. Stat. Ann. § 996, App. 133a.

were not fully available to them when extensive unreasonable and unnecessary treatment was rendered prior to rulings by the workers' compensation referees.[3] *Laundry Owners Mut. Liab. Ins. Ass'n.*

Act 57 regulations, finally published approximately two months prior to the Court of Appeals' decision, pertain to the utilization review cost containment provisions. The regulations established that the Supersedeas Fund was available to reimburse employers for bills for treatment paid subject to a Utilization Review determination which is ultimately found to be unreasonable and unnecessary. 34 Pa. Code § 127.208(g) (Pennsylvania Bulletin, Vol. 28, No. 3, January 17, 1998), App. 136a-137a. Accordingly, employers and insurers must reimburse providers that may have been unpaid during the utilization review process, and continue payment while the petition remains pending before the workers' compensation judge.[4]

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3. Employers and insurers are annually assessed pursuant to a formula set forth at 34 Pa. Code § 121.23(a), App. 135a. The formula requires the assessment to be 100% of the amount reimbursed to insurers and self-insurers in the proceeding year.

4. The Commonwealth Court has also recently instructed that it is the employer, not the worker or the provider, who maintains the burden to prove that the treatment was not reasonable and unnecessary during the entire pendency of the review and appeal. *Topps Chewing Gum v. Workers' Compensation Appeal Board (Wickizer)*, __ A.2d __, 1998 WL 191706 (Pa. Cmwlth., filed April 23, 1998) (No. 1996 C.D. 1997). The Commonwealth Court's recognition of this unshifting burden of proof, coupled with the provider's independent standing to appeal the utilization review determination and Act's prohibition against any provider taking payment directly from a worker in a workers' compensation case, demonstrate that the risk of harm pales in comparison to the significant financial harm Pennsylvania employers and insurers suffer under the utilization review process as re-drafted by the Third Circuit *See* App. 32a.

The impact of the Third Circuit's decision on the Supersedeas Fund is potentially cataclysmic to the Pennsylvania workers' compensation system.

A. District Court Proceedings. Before the district court, the School District of Philadelphia was the sole self-insured defendant named in the class action suit. C.A. App. A74-A120, A163-A196. The School District also moved for dismissal on the grounds that it could not be sued for violations of the Due Process Clause of the Fourteenth Amendment under 42 U.S.C. § 1983 because it did not promulgate any policies or procedures or develop any standard operating practice pertaining to utilization review that could have caused a deprivation of plaintiff Susan Hansen's constitutional rights.

In response, plaintiffs filed a cross-motion for summary judgment solely on the state action issue. The district court denied the motions of the plaintiffs and the School District, ruling that the limited record was insufficient to determine, as a matter of law, whether the School District was a state actor for purposes of the civil rights action. App. 105a. The plaintiffs moved for a final order under Fed. R. Civ. P. 54(b), which the district court denied. In the district court's opinion, the district court explained that the issue of "state actor" had not finally been ruled upon because the status of the School District remained unresolved in the proceedings. App. 78a-79a.

After the motion to dismiss filed by the state officials was granted and the utilization review process was determined to be constitutionally sound, the School District filed a motion on the pleadings. The School District's motion was granted and the plaintiffs appealed the district court's decisions. App. 40a.

B. The Proceedings In The Court Of Appeals. The Third Circuit accurately reiterated the procedural posture which led to the School District's dismissal from the case and limited

its holding on the state actor issue to the private insurance carriers. *See* App. 17a, 47a.

The Third Circuit recognized that Section 1983 actions pertain only to federal rights deprived by a person acting "under color of state law." *Citing Groman v. Township of Manalapan*, 47 F.3d 628, 633 (3d Cir. 1995). App. 16a-17a. No analysis was provided by the court regarding the fundamental issue of whether workers' compensation medical benefits constitute rights categorically subject to due process protection.

The Third Circuit initially identified the Employee's interest at issue as the "interest . . . in the uninterrupted payment of their medical benefits pending the final administrative decision on their case," App. 34a. *Mathews v. Eldridge*, 424 U.S. 319, 340. However, in its analysis, the Third Circuit actually applied a different interest. The interest applied was a worker's "interest in the relief that the medical treatment provides to injured employees." App. at 36a.

REASONS FOR GRANTING THE WRIT

The School District of Philadelphia adopts and incorporates herein by reference the "reasons for granting the petition" contained in the petition for a writ of certiorari, filed June 11, 1998 captioned *American Manufacturers Mutual Ins. Co., et al. v. Delores Scott Sullivan, et al.*[5] Although the issue regarding the School District's status as a state actor remains undetermined in this litigation, the reasons for granting the petition for certiorari set forth in the private insurers' petition apply equally

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5. The School District disagrees, however, with the private insurers' position that the Third Circuit properly decided the issue of notice. Rather, the School District maintains that the notice provided was sufficient to advise workers' compensation claimants that their treatment was being reviewed. *See Sauceda v. Dep't of Labor & Industries*, 917 F.2d 1216 (9th Cir. 1990).

to self-insured employers and private insurers in Pennsylvania. 77 Pa. Stat. Ann. § 501.

Furthermore, the Third Circuit's expansion of the reach of due process protection to encompass all medical services, irrespective of whether the specific services are compensable under state law, warrants further review. The Third Circuit's interest analysis conflicts with *Mathews* and the need for guidance from this Court is acute. The federal district court and the Court of Appeals of the Third Circuit have pioneered precedent setting judicial legislation striking state procedures regarding state created benefits as unconstitutional. *Sullivan v. Barnett*, 139 F.2d 158 (3rd Cir. 1998); *Baksalary v. Smith*, 579 F. Supp. (E.D. Pa. 1984), *aff'd*, 772 F.2d 893 (3rd Cir. 1985), *cert. denied*, 469 U.S. 1146 (1985). Thus the far reaching national impact of this decision should not escape review.

Moreover, the decision below is erroneous in likening the Pennsylvania state workers' compensation system to the prison and social security systems and the issues addressed are important. The legislature of the Commonwealth of Pennsylvania and other states should be unfettered by federal judicial legislation and micromanagement.

I.

THE FOURTEENTH AMENDMENT'S APPLICABILITY TO STATE-CREATED BENEFIT SYSTEMS WARRANTS FURTHER REVIEW.

A. The Third Circuit's Property Interest Analysis Is Inconsistent With *Mathews* And Due Process Principles Of The Fourteenth Amendment.

The Third Circuit decision, expanding the reach of Fourteenth Amendment Due Process rights, and this court's ruling in *Mathews*, is significant and warrants this Court's

plenary review. The balancing test set forth in *Mathews* instructed that, in a due process challenge to state created benefits, a worker's interest in the uninterrupted receipt of benefits is the interest the Court should consider in assessing the degree of due process required. The test the Third Circuit applied herein focused on the presumed relief the challenged treatment provides the worker. Thus the Third Circuit extended the state defined interest in workers' compensation benefits, generally, to provide a constitutionally protected interest in the "relief" the worker "believes" he or she has in treatment the worker chooses to undergo.

The Pennsylvania statutes and case law simply do not support the Third Circuit's finding of a protected property interest in any medical care a worker chooses merely because the worker believes the treatment provides relief. Pennsylvania law only provides for medical services that are reasonable, necessary and causally related to the work injury. 77 Pa. Stat. Ann. § 531(1)(i); *Green v. Workmen's Compensation Appeal Board (Ass'n for Retarded Citizens)*, 670 A.2d 1216 (Pa. Cmwlth. 1996); *Mulholland v. Workmen's Compensation Appeal Board (Bechtel Constr.)*, 669 A.2d 465 (Pa. Cmwlth. 1995); *Glinka v. Workmen's Compensation Appeal Board (Sears, Roebuck and Co.)*, 521 A.2d 503 (Pa. Cmwlth.), *appeal denied*, 533 A.2d 714 (Pa. 1987).

The Pennsylvania appellate courts have also held that the relationship between injured workers and employers is a private contractual relationship. *Henderson v. Workmen's Compensation Appeal Board (Rockwell Int'l., Inc.)*, 452 A.2d 277, 279 (Pa. Cmwlth. 1982) (President Judge Crumlish). The *Henderson* court rejected the notion that the mere existence of a system for resolving disputes between private parties gives rise to due process protection under the Fourteenth Amendment to the United States Constitution.

Justice Rehnquist has numerously identified similar decisions expanding protected state interests by federal courts as "significant steps . . . that . . . merit plenary consideration by the full Court." *Griffeth v. Detrich*, 603 F.2d 118, 121 (9th Cir. 1979), *cert. denied*, 445 U.S. 970 (1980) (Rehnquist, J., dissenting); *accord Cleveland Board of Educ. v. Loudermill*, 470 U.S. 532 (Rehnquist, J., dissenting 1985). In *Cleveland*, Justice Rehnquist reiterated this Court's definition of "property interests" set forth in *Board of Regents of St. Colleges v. Roth*, 408 U.S. 564, 577 (1972):

> Property interests, of course, are not created by the Constitution. Rather, they are created and their dimensions are defined by existing rules or understandings that stem from an independent source such as state law--rules or understandings that secure certain benefits and that support claims of entitlement to those benefits.

470 U.S. 532, 559.

Justice Rehnquist cautioned that it is the role of the courts to focus on the state's definition of the property right in question for purposes of applying the Due Process Clause and that courts should refrain from judicially legislating to create property rights where the state legislature has not intended to confer the right. *Cleveland*. Similarly, in the matter sub judice, the Third Circuit has reached beyond the interests provided in the state statute and "in one legislative breath"[6] conferred a new right on Pennsylvania workers: a property interest in any medical service they chose if, the worker subjectively believes, the treatment provides "relief." *See* Wright & Miller, 16B Fed. Proc. & Proc. Juris. 2d § 4030 (modern due-process protection analysis requires the Supreme Court to carefully review state court

6. *Cleveland*, 470 at 559.

determinations "with substantial respect to defining the expectations created by state law, and with substantial independence in measuring the protectibility of those expectations").

Colorado has recently rejected expanding the property interest its injured workers have in workers' compensation benefits to include a property interest "in either receiving treatment from a specific medical provider or in receiving a specific type of treatment." *Colorado Compensation Ins. Auth. v. Nofio*, 886 P.2d 714, 719 (1994). Colorado's workers' compensation statute provided a limited property interest in treatment and supplies that "may reasonably be needed at the time of the injury or occupational disease and thereafter during the disability to cure and relieve the employee from the effects of the injury." *Nofio* citing § 8-42-101(1)(a), 3B C.R.S. (1994 Supp.).

The Colorado Supreme Court reasoned that because the state law did not grant the worker the right to receive medical care from a particular medical provider or to receive a particular type of treatment, no property right in that specific treatment exists and the procedure to determine whether the treatment is necessary does not expand the workers' substantive rights.

Pennsylvania's Workers' Compensation Act provides nothing more than reasonable and necessary treatment causally related to the work injury. If this right is to be expanded, it is the state legislature not the circuit courts who should expand the interest.[7]

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7. Pennsylvania State courts have consistently maintained that due process is not implicated where retirement benefits sought are outside the purview of statute. A state employee "has only those rights created by statute and none beyond it." *Rowan v. Pennsylvania State Employes' Retirement Bd*, 685 A.2d 238 (Pa. Cmwlth. 1996), *citing Bittenbender v. State Employees' Retirement Bd*, 622 A.2d 403, 405 (Pa. Cmwlth. 1992).

The decision below, therefore, contradicts this court's *Mathews* analysis. This Court should grant certiorari to review this important conflict.

B. The Expansion Of The Fourteenth Amendment Due Process Analysis By The Third Circuit Has Impermissibly Reversed Five Years Of Legislative Reform Efforts And Will Cost Pennsylvania Citizens Incalculable Hardship.

The legislature of Pennsylvania enacted the medical cost containment reform, which is the subject of this action, with the express intent of serving citizens of Pennsylvania. Insurers and employers have, in good faith, operated under the legislatively recognized reformed procedures. The Third Circuit's expansion of the principles of due process into newly created state property interests is potentially devastating to the Pennsylvania system and has far reaching implications beyond the Third Circuit and Pennsylvania's workers' compensation system. The federal court below erred in its attempt to substitute its judgment for that of the legislature. *See United States v. Carolene Prods. Co.*, 304 U.S. 144 (1938).

The issues presented in the petitions for writ of certiorari of the School District of Philadelphia and the private insurers are important and this Court's review essential.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

APPENDIX A — JUDGMENT AND OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT FILED MARCH 13, 1998

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 96-2140

DELORES SCOTT SULLIVAN; WILLIAM BATTLE; ANTHONY CANCILA; CHARLES MATTHEWS; CHRISTOPHER COSTELLO; LISA LEX; SUSAN HANSEN, On Their Own Behalf and on Behalf of All Similarly Situated Class Plaintiffs; PHILADELPHIA AREA PROJECT ON OCCUPATIONAL SAFETY AND HEALTH; THE PHILADELPHIA FEDERATION OF TEACHERS, Local 3, AFL-CIO

v.

ROBERT BARNETT, Secretary of Labor and Industry for the Commonwealth of Pennsylvania; FRANK BEAL, Director of the Pennsylvania Bureau of Workers Compensation; CONSTANCE B. FOSTER, Insurance Commissioner for the Commonwealth of Pennsylvania; CATHERINE BAKER KNOLL, Treasurer, Commonwealth of Pennsylvania; JOHN P. O'MALLEY, Director, State Workers' Insurance Fund; AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY; CIGNA CORPORATION; CONTINENTAL CASUALTY COMPANY; USF&G INSURANCE COMPANY; ZURICH AMERICAN INSURANCE COMPANY; SCHOOL DISTRICT OF PHILADELPHIA; JOHNNY J. BUTLER, Secretary of Labor and Industry of the Commonwealth of Pennsylvania; RICHARD A. HIMLER, Director of the Pennsylvania Bureau of Workers Compensation; COMMERCIAL UNION INSURANCE COMPANY; DONEGAL MUTUAL INSURANCE COMPANY; HARTFORD INSURANCE COMPANY

Appendix A

Delores Scott Sullivan, William Battle, Louis Baumgartner,* Anthony Cancila, William C. Dillon,* Terrence Ervine,* Charles Matthews, Christopher Costello, Lisa Lex, Susan Hansen, Philadelphia Area Project on Occupational Safety and Health and Philadelphia Federation of Teachers,

Appellants

On Appeal from the United States District Court
for the Eastern District of Pennsylvania
(D.C. No. 95-cv-00201)

Present: Mansman, Nygaard and Garth, *Circuit Judges*

JUDGMENT

This cause came on to be heard on the record from the United States District Court for the Eastern District of Pennsylvania and was argued by counsel on September 11, 1997.

On consideration whereof, it is now here ordered and adjudged by this Court that the supersedeas provisions of 77 Pa. Const. Stat. Ann. sections 531(5) and (6) are unconstitutional in that they violate an employee's procedure due process rights by filing to provide adequate notice that his/her medical benefits may be suspended upon the invocation of utilization review and by not granting the employee an opportunity to respond in writing before that termination takes effect. It is also ordered and adjudged that the private insurance companies are state actors and thus may be joined in a section 1983 action when they elect to invoke the supersedeas provisions to terminate or suspend an employee's

* pursuant to Rule 12(a) FRAP

constitutionally protected interests in receiving medical benefits. Thus, the judgment of the said District Court entered December 19, 1996, is hereby reversed and the cause is remanded to the District Court for further proceedings in accordance with this opinion. On remand, among other issues, the District Court should address the issue of reconsideration fees, the question of certifying a class, and for the first time, it should consider whether it has subject matter jurisdiction over the Commonwealth Defendants in light of Eleventh Amendment sovereign immunity.

Costs taxed against appellees.

All of the above in accordance with the opinion of this court.

ATTEST:

s/ P. Douglas Sisk
Clerk

Dated: 13 March 1998

Appendix A

Filed March 13, 1998

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 96-2140

DELORES SCOTT SULLIVAN; WILLIAM BATTLE; ANTHONY CANCILA; CHARLES MATTHEWS; CHRISTOPHER COSTELLO; LISA LEX; SUSAN HANSEN, On Their Own Behalf and on Behalf of All Similarly Situated Class Plaintiffs; PHILADELPHIA AREA PROJECT ON OCCUPATIONAL SAFETY AND HEALTH; THE PHILADELPHIA FEDERATION OF TEACHERS, Local 3, AFL-CIO

v.

ROBERT BARNETT, Secretary of Labor and Industry for the Commonwealth of Pennsylvania; FRANK BEAL, Director of the Pennsylvania Bureau of Workers Compensation; CONSTANCE B. FOSTER, Insurance Commissioner for the Commonwealth of Pennsylvania; CATHERINE BAKER KNOLL, Treasurer, Commonwealth of Pennsylvania; JOHN P. O'MALLEY, Director, State Workers' Insurance Fund; AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY; CIGNA CORPORATION; CONTINENTAL CASUALTY COMPANY; USF&G INSURANCE COMPANY; ZURICH AMERICAN INSURANCE COMPANY; SCHOOL DISTRICT OF PHILADELPHIA; JOHNNY J. BUTLER, Secretary of Labor and Industry of the Commonwealth of Pennsylvania; RICHARD A. HIMLER, Director of the Pennsylvania Bureau of Workers Compensation; COMMERCIAL UNION INSURANCE

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COMPANY; DONEGAL MUTUAL INSURANCE COMPANY; HARTFORD INSURANCE COMPANY

Delores Scott Sullivan, William Battle, Louis Baumgartner,* Anthony Cancila, William C. Dillon,* Terrence Ervine,* Charles Matthews, Christopher Costello, Lisa Lex, Susan Hansen, Philadelphia Area Project on Occupational Safety and Health and Philadelphia Federation of Teachers,

Appellants

On Appeal from the United States District Court
for the Eastern District of Pennsylvania
(D.C. No. 95-cv-00201)

Argued Thursday, September 11, 1997

BEFORE: MANSMANN, NYGAARD and GARTH, Circuit Judges

(Opinion filed March 13, 1998)

* * *

OPINION OF THE COURT

GARTH, *Circuit Judge:*

The issue we must address on this appeal is whether Pennsylvania's Workers' Compensation Act, 77 Pa. Const. Stat. Ann. § 531(5) and (6) (West Supp. 1997), which provides for the

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* pursuant to Rule 12(a) FRAP

supersedeas of an employee's medical benefits without prior notice or an opportunity to be heard, violates the requisites of procedural due process. We hold that it does. Accordingly, we reverse.

I.

The Pennsylvania Workmen's Compensation Act ("the Act"), 77 Pa. Const. Stat. Ann. § 1 *et seq.*, establishes a compulsory insurance system for employers that provides compensation to employees who sustain work-related injuries and occupational diseases without regard to an employee's negligence. *See* 77 Pa. Const. Stat. Ann. § 431. To guarantee the payment of an employee's claims, the Act requires employers to obtain insurance — either through a private insurance carrier or through the State Workmen's Insurance Fund ("SWIF") — or to self-insure. *See id.* § 501. When an employer purchases insurance, the insurance company assumes the employer's statutory liabilities. *See id.* §§ 501, 701.

On July 2, 1993, the Pennsylvania legislature amended the Act by enacting Act 44. The purpose of Act 44 was to contain the spiraling costs of medical treatment for work-related injuries. Codified at 77 Pa. Const. Stat. Ann. § 531(5) and (6), Act 44 created a utilization review process under which the reasonableness and/or necessity of an employee's medical treatment could be reviewed. It is these provisions of Act 44 which create the utilization review process and the corresponding supersedeas that are challenged in this action. Utilization review is a process whereby medical providers assess the reasonableness or necessity of current, prospective, or past medical treatment.

Section 531(5) provides the mechanism by which utilization review is invoked. It states in pertinent part:

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> The employer or insurer shall make payment and providers shall submit bills and records in accordance with the provisions of this section. All payments to providers for treatment provided pursuant to this act shall be made within thirty (30) days of receipt of such bills and records *unless the employer or insurer disputes the reasonableness or necessity of the treatment provided pursuant to paragraph (6)* . . . .

77 Pa. Const. Stat. Ann. § 531(5) (West 1997) (emphasis added). Hence, an employer or insurer must pay an employee's medical expenses within thirty (30) days of receipt of the medical bills unless the employer or insurer requests utilization review. The decision to invoke utilization review is made independently by the employer or insurer.

A.

Section 531(6) outlines the utilization review process. Section 531(6) provides:

> . . . disputes as to reasonableness or necessity of treatment by a health care provider shall be resolved in accordance with the following provisions:
>
> (I) The reasonableness or necessity of all treatment provided by a health care provider under this act may be subject to prospective, concurrent or retrospective utilization review at the request of an employe [sic], employer or insurer. The department shall authorize utilization review organizations to perform utilization review under this act. Utilization review of all treatment rendered by a health care provider shall be performed

> by a provider licensed in the same profession and having the same or similar specialty as that of the provider of the treatment under review. Organizations not authorized by the department may not engage in such utilization review.
>
> (ii) The utilization review organization shall issue a written report of its findings and conclusions within thirty (30) days of a request.
>
> (iii) The employer or the insurer shall pay the cost of the utilization review.
>
> (iv) If the provider, employer, employe [sic] or insurer disagrees with the finding of the utilization review organization, a petition for review by the department must be filed within thirty (30) days after receipt of the report. The department shall assign the petition to a workers' compensation judge for a hearing or for an informal conference under [77 Pa. Const. Stat. Ann. § 711.1]. The utilization review report shall be part of the record before the workers' compensation judge. The workers' compensation judge shall consider the utilization review report as evidence but shall not be bound by the report.

77 Pa. Const. Stat. Ann. § 531(6).

Thus, utilization review is invoked when an employee, employer, or insurer requests review of specific medica treatment performed.[1]

1. An employee is not likely to request utilization review, however, because the invocation of that process can result in the termination of the employee's medical benefits pending such review.

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The party seeking review submits its request to the Bureau of Workers' Compensation ("the Bureau") on a Bureau-prescribed form entitled "Utilization Review: Initial Request" ("Initial Request"). The Bureau reviews the Initial Request to ensure that it is properly completed — i.e., that all information required by the form is provided. *See* 34 Pa. Code § 127.452. The Bureau's review of the Initial Request does not address the legitimacy or lack thereof of the request for utilization review.

If the Initial Request is improperly completed (i.e., does not provide all pertinent information requested by the form), the Bureau denies the request for review and sends the form back to the party. If the Initial Request is completed properly, the request is approved and the party requesting review must serve a copy of the Initial Request upon the remaining interested parties, including the employee, the employer, the insurer, and the health care provider, as appropriate. *See* 34 Pa. Code § 127.452.

At this point, according to the Act's regulations, an employer or insurer with a Bureau-approved request may suspend payment for the medical treatment in question. *See id.* § 127.208.[2] The

2. Section 127.208 of the regulations pertinent to the Act provides in part:

> (e) The 30-day period in which payment shall be made to the provider may be tolled only if review of the reasonableness or necessity of the treatment is requested during the 30-day period under the UR provisions . . . . The insurer's right to suspend payment shall continue throughout both the initial review and the reconsideration review of the UR process. The insurer's right to suspend payment shall further continue beyond the UR process to a proceeding before a Workers' Compensation judge, unless there is a UR determination made at reconsideration that the treatment is reasonable or necessary.

34 Pa. Code § 127.208(e) (1996).

Act does not require — but permits — suspension of medical benefits. In addition, medical providers are not forbidden from continuing to furnish medical services to employees who are subjected to such review, although any such treatment is rendered with the risk that the medical provider ultimately may not be compensated depending upon the resolution of the utilization review. Furthermore, although the employee is given notice that the Initial Request for utilization review has been filed, there is no indication on that form that an employee's medical benefits may be terminated for and during the disputed treatment. Further, the Initial Request does not provide any information or explanation regarding what utilization review entails.

After a request for review is properly filed, the Bureau randomly assigns the case to a Utilization Review Organization ("URO"),[3] and the Bureau again notifies all interested parties that the case has been assigned by sending out a Notice of Assignment form. *See* 34 Pa. Code § 127.453. The Notice of Assignment is a copy of the notice that is sent to the URO, advising the URO that a particular case has been assigned to it. The Notice of Assignment, like the Initial Request, does not inform employees that their medical benefits may be suspended nor does it advise employees of procedures under which their suspension may be protested.

The review process is narrowly tailored to the task of determining whether specific medical treatment is or was

3. "Utilization Review Organizations" are defined as

> those organizations consisting of an impartial physician, surgeon or other health care provider or a panel of such professionals and provides as authorized . . . for the purpose of reviewing the reasonableness and necessity of a health care provider pursuant to section 531(6).

77 Pa. Const. Stat. Ann. § 29 (West 1997).

reasonable or necessary. Utilization review is conducted by a health care provider[4] who has "the same or similar specialty" as the provider who conducted the treatment in question. *See* 77 Pa. Const. Stat. Ann. § 531(6)(i). Accordingly, the reviewer must apply generally accepted treatment protocols to assess the reasonableness or necessity of the questioned treatment. *See* 34 Pa. Code § 127.467. The URO may not request, seek, or obtain independent medical examinations or reports. *See id.* § 127.461. Rather, the review is solely based upon the medical records of the treating medical provider and any discussions that the URO has had with the medical provider concerning the treatment. *See id.* §§ 127.461, 127.469.[5] Lastly, the URO's role is narrowly defined to address exclusively whether the medical treatment in question is reasonable and/or necessary. *See* 34 Pa. Code § 127.470.

The URO must assume that the employee's medical condition is a work-related injury. *See id.* In addition, the URO does not consider whether the employee is still disabled, whether the employee

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4. A "health care provider" is defined as

> as any person, corporation, facility or institution licensed or otherwise authorized by the Commonwealth to provide health care services, including, but not limited to, any physician, coordinated care organization, hospital, health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, psychologist, chiropractor or pharmacist and an officer, employe [sic] or agent of such person acting in the course and scope of employment or agency related to health care services.

77 Pa. Const. Stat. Ann. § 29.

5. The URO must give the treating medical provider an opportunity to discuss the challenged treatment. *See* 34 Pa. Code § 127.469. Neither the statute nor the regulations make any provision for giving the affected employee the same opportunity.

has obtained maximum medical improvement, or whether the fees charged are reasonable. As noted, the URO's exclusive function is to determine the reasonableness or necessity of the prescribed treatment in question.

The URO must issue a report of its findings and conclusions within thirty (30) days of a request.[6] *See* 77 Pa. Const. Stat. Ann. § 531(6)(ii). The written report must contain findings, conclusions, and citations to generally accepted treatment protocols and medical literature, as appropriate. *See* 34 Pa. Code § 127.472. The URO sends the report to the Bureau which then sends a copy to all interested parties. *See id.* § 127.476. The employer or insurer pays for the initial utilization review. *See* 77 Pa. Const. Stat. Ann. § 531(6)(iii); 34 Pa. Code § 127.477.

B.

Originally, Act 44 permitted reconsideration of the URO's determination if filed within thirty (30) days of the URO's report. *See* 77 Pa. Const. Stat. Ann. § 531(6)(iv). The review on reconsideration mirrored the initial utilization review except that a different URO conducted the review and the Bureau advanced the costs of reconsideration and subsequently billed the losing party. *See* 34 Pa. Code § 127.514. Thus, as with the utilization review, an employee could not testify before a URO concerning the medical treatment on reconsideration. Further, parties were not notified before invoking reconsideration review that they would be billed for the costs of reconsideration review if they lost.

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6. The regulations provide that the URO must complete the review and make a determination within thirty (30) days of receiving the medical provider's records or within thirty-five (35) days of the date that the URO received the Notice of Assignment, whichever is earlier. *See* 34 Pa. Code § 127.465.

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If a party disagreed with the URO's determination on reconsideration, it could file a Petition for Review with the Bureau for *de novo* review before a Workers' Compensation Administrative Law Judge ("ALJ"). If the employee prevailed upon reconsideration, the supersedeas was lifted pending this *de novo* hearing. If the employee lost the reconsideration review, the supersedeas remained in effect. *See id.* § 127.208(f).

Even if the medical services provided were ultimately found to be reasonable and/or necessary, an employee's benefits could be suspended for a considerable length of time pending the initial utilization review, reconsideration, and *de novo* review by an ALJ. While the Act requires the initial utilization review to occur within thirty (30) days of a request, *see* 77 Pa. Const. Stat. Ann. § 531(5)(ii), and reconsideration to be filed within thirty (30) days of the URO's determination and decided within 30-35 days thereafter, *see* 34 Pa. Code § 127.508, there is no time-frame specified for adjudication and resolution before the ALJ. Accordingly, employees could have waited months or even years without medical benefits before the reasonableness or necessity of their treatment was resolved.

In 1996, the Act was amended yet again by Act 57. Act 57 streamlined the utilization review process by eliminating the reconsideration process, thereby allowing for faster *de novo* review by an ALJ. Thus, after the initial URO issues its decision, the losing party no longer need seek reconsideration by another URO, but rather may petition for *de novo* review by an ALJ. Under Act 57, if the initial URO rules in favor of the employee, the supersedeas is lifted pending the ALJ's review. If the URO rules against the employee, the supersedeas remains in effect until after the ALJ renders his/her decision. *See id.* § 127.208(e). In all other material respects the provisions of Act 44 remained in effect and are not challenged here.

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II.

The Plaintiffs (hereinafter, collectively "Sullivan") in the present § 1983 case are ten individual employees[7] and two organizations representing employees who claim that their medical benefits were suspended without regard to due process: the Philadelphia Area Project on Occupational Safety and Health ("PhilaPOSH"),[8] and the Philadelphia Federation of Teachers ("PFT").[9] Sullivan claims that the amendments to the Act violated the Plaintiffs' constitutional right to due process under the Fourteenth Amendment by permitting their employers and/or insurers to suspend the payment of their workers' compensation medical benefits without prior notice and without affording them an opportunity to be heard.[10]

7. The Plaintiffs-Appellants are Delores Scott Sullivan, William Battle, Louis Baumgartner, Anthony Cancila, William C. Dillon, Terrence Ervine, Charles Matthews, Christopher Costello, Lisa Lex, and Susan Hansen.

8. PhilaPOSH is a non-profit organization comprised of over 2000 unions and individual members, representing approximately 300,000 workers in Southeastern Pennsylvania. PhilaPOSH advocates for occupational safety and the rights of injured workers. Plaintiffs alleged that several members of PhilaPOSH had been directly affected by the utilization review procedures challenged in this litigation. *See* Am. Compl. at ¶ 15.

9. In its order dated March 30, 1995, the district court permitted the PFT to intervene as a plaintiff in this action.

10. The Fourteenth Amendment provides, in pertinent part:

> Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

U.S. Const. amend. XIV, § 1.

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Sullivan filed the amended complaint in this action on May 21, 1996, three months before the amendments in Act 57 rescinding reconsideration review took effect.

The Defendants in this action include various state officials responsible for administering the Act ("the Commonwealth Defendants"),[11] the director of SWIF,[12] the School District of Philadelphia ("the School District"), and several insurance companies.[13]

The insurance company defendants and the School District moved to dismiss the complaint on the grounds that there was no state action involved in suspending Sullivan's medical benefits.[14] Sullivan filed a motion for partial summary judgment on the issue

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11. The state officials are the Secretary of Labor and Industry, Robert Barnett (Appellees name Johnny Butler in this position); Director of Pennsylvania's Bureau of Workers' Compensation, Richard Himler; Insurance Commissioner for the Commonwealth of Pennsylvania, Linda Kaiser; and Treasurer for the Commonwealth, Catherine Baker Knoll.

12. The Director of SWIF is Ralph Chase.

13. The insurance companies involved in this action are American Manufacturer's Mutual Insurance Company, Cigna Corporation, Continental Casualty Company, USF&G Insurance Company, and Zurich American Insurance Company.

14. The insurance company defendants contended that there was no state action with respect to the private decisions that they made. The School District claimed that there was no state action because it did not participate in the decision-making process concerning the invocation of utilization review (and corresponding termination of medical benefits) because it contracted out the payment of its medical liabilities under the Act to a private company which is not a party to the present action. *See* Sch. Dist.'s Mem. in Supp. Mot. to Dismiss at 1-4 (district court docket # 11, 12).

that the insurers and the School District were state actors subject to the constraints of due process. In its opinion and order dated January 24, 1996, the district court ruled that the private insurers were not state actors, but at that time did not decide the state action issue with respect to the School District as the record was incomplete and more discovery was needed. *See Sullivan v. Barnett*, 913 F. Supp. 895 (E.D. Pa. 1996) (hereinafter, "Sullivan I").

On May 28, 1996, Sullivan moved for class certification to represent the class of workers who have had or will have their medical benefits suspended under Pennsylvania's utilization review procedures without advance notice or an opportunity to be heard prior to supersedeas of benefits under section 531(5) and (6). *See* Am. Compl. at P 17. Holding that the supersedeas provisions did not offend due process, the district court dismissed the complaint with respect to the Commonwealth Defendants and the School District by orders dated November 7, 1996, *see Sullivan v. Butler*, 1996 WL 654032 (E.D. Pa. Nov. 7, 1996) (hereinafter, "Sullivan II"), and December 13, 1996, respectively, without certifying the plaintiff-class. This appeal followed.

We have jurisdiction over this appeal pursuant to 28 U.S.C. § 1291. Our review over the district court's rulings is plenary. *See Weiner v. The Quaker Oats Co.*, 129 F.3d 310, 315 (3d Cir. 1997).

III.

In order for Sullivan to prevail on her claims that the Act does not provide adequate notice nor an opportunity to be heard before her benefits are terminated, the Defendants must be held to be state actors or to be acting under color of state law.[15]

15. Section 1983 provides a cause of action to individuals who have been deprived of a federal right by a person acting "under color of state law." *See* (Cont'd)

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The Commonwealth does not dispute that it is a state actor, and indeed, it would be hard-pressed to do so in light of the fact that it was the Commonwealth that enacted the supersedeas provisions of 77 Pa. Const. Stat. Ann. § 531(5) and (6) which deprive Sullivan of the Workers' Compensation medical benefits to which she is entitled. Nor has SWIF disputed the fact that it is a state actor. *See* Commonwealth Br. at 20 n.12; *see also Rumph v. State Workmen's Ins. Fund*, 964 F. Supp. (E.D. Pa. 1997); *Baksalary v. Smith*, 579 F. Supp. 218, 230 (E.D. Pa. 1984). Further, the School District apparently does not now contest that it is a state actor, as it has not briefed the issue on appeal.[16] The insurers, however, deny that their actions in invoking relief under the supersedeas provisions appurtenant to the utilization review process constitute state action. We cannot agree.

State action has been characterized as one of the most troublesome issues of constitutional law. *See* Henry C. Strickland,

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Groman v. Township of Manalapan, 47 F.3d 628, 633 (3d Cir. 1995). The "under color of state law" requirement of § 1983 and the "state action" element of the Fourteenth Amendment have been interpreted to be "identical in most contexts," *Id.* at 639 n.15; *see also Lugar*, 457 U.S. at 935 n.18. Thus, private parties can be held liable for the alleged due process violations only if "it can be fairly said that the [government] is responsible for the specific conduct of which the plaintiff complains" — here, the suspension of employees' Workers' Compensation medical benefits. *Edmonson v. Leesville Concrete Co.*, 500 U.S. 614, 632 (1991) (O'Connor, J. dissenting) (quoting *Blum v. Yaretsky*, 457 U.S. 991, 1004) (1982).

16. In *Sullivan I*, the district court initially denied the School District's motion to dismiss premised upon the state action issue. *See Sullivan I*, 913 F. Supp. at 905. However, because the district court held that the supersedeas provisions of the Act did not violate procedural due process in Sullivan II, the district court did not ultimately find it necessary to reach the state action issue with respect to the School District.

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The State Action Doctrine and the Rehnquist Court, 18 Hastings Const. L.Q. 587, 588 (1991). Various cases have led to differing results in factual scenarios that, at least upon first impression, appear to be similar. Compare *Mark v. Borough of Hatboro*, 51 F.3d 1137 (3d Cir. 1995) (concluding that state action existed in context of volunteer fire department), with *Groman v. Township of Manalapan*, 47 F.3d 628 (3d Cir. 1995) (holding that state action did not attach to actions of a volunteer first aid squad). Indeed, the state action inquiry necessarily depends upon the factual contexts in which the controversies arise. *See Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 939 (1982); *Jackson v. Wilmington Parking Auth.*, 365 U.S. 715, 722 (1961) ("Only by sifting through facts and weighing circumstances can the nonobvious involvement of the State in private conduct be attributed its true significance."); *Groman*, 47 F.3d at 639 n.16. To compound the confusion surrounding a state action examination, courts have employed various tests and standards that have been anything but a model of clarity. *See Edmonson v. Leesville Concrete Co.*, 500 U.S. 614, 632 (1991) (O'Connor, J. dissenting) ("Unfortunately, [Supreme Court] cases deciding when private action might be deemed that of the state have not been a model of consistency.").

In order to analyze the state action issue before us, it is critical to place the insurer's role within the Workers' Compensation system in its proper context. The Act provides no-fault compensation to all employees within the Commonwealth for all injuries sustained during the course of one's employment. In exchange for this guarantee of automatic compensation for wage loss and medical costs without regard to proof or fault, employees lost their right to sue their employers in tort. *See Winterberg v. Transportation Ins. Co.*, 72 F.3d 318 (3d Cir. 1995). The Act abolishes an employer's common law defenses

and strips an employee of his/her right to sue upon common law causes of action. Thus, the Workmen's Compensation scheme in Pennsylvania has been held to be the *exclusive* remedy available to an injured worker. *See* 77 Pa. Const. Stat. Ann. § 481(a).[17] *Cf. Travelers Indemnity Co. v. DiBartolo*, 131 F.3d 343, 350-51 (3d Cir. 1997) (holding an employer's voluntary purchase of uninsured motorist coverage is a fringe benefit since it is no longer mandated by state law and, thus, is not subject to the exclusivity provision of the Workmen's Compensation Act). The system is mandatory; an employee cannot opt-out of Pennsylvania Workers' Compensation scheme. *See* 77 Pa. Const. Stat. Ann. § 461 (historical notes).

The benefits provided to employees under the Act are a constitutionally protected entitlement. None of the parties disputes this. *See, e.g., Sullivan* II at 4; *see also Baksalary*, 579 F. Supp. at 224-225. The Commonwealth has created this entitlement, and the Commonwealth guarantees that these benefits will be paid to an injured employee.[18]

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17. 77 Pa. Const. Stat. Ann. § 481(a) states, in pertinent part:

> The liability of an employer under this act shall be exclusive and in the place of any and all other liability to such employes [sic] . . . or anyone otherwise entitled to damages in any action at law or otherwise on account of any injury or death . . . .

77 Pa. Const. Stat. Ann. § 481(a) (West 1992).

18. The Commonwealth guarantees that Workmen's Compensation benefits will be paid by imposing a statutory obligation upon the employer to pay for all work-related injuries of his/her employees. If the employer's insurance company becomes insolvent, however, the Workers' Compensation Security Fund, a fund administered and created by the Commonwealth, assumes the responsibility of paying the benefits to eligible employees. *See* 77 Pa. Const. Stat. Ann. § 1053.

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In creating and executing this system of entitlements, the Commonwealth has enacted a complex and interwoven regulatory web enlisting the Bureau, the employers, and the insurance companies. The Commonwealth extensively regulates and controls the Workers' Compensation system. Although the insurance companies are private entities, when they act under the construct of the Workers' Compensation system, they are providing public benefits which honor State entitlements. In effect, they become an arm of the State, fulfilling a uniquely governmental obligation under an entirely state-created, self-contained public benefit system. It is a "system which the government alone administers." *Edmonson,* 500 U.S. at 622. Thus, we conclude the insurance companies are a partner or an arm of the State in implementing legislation that administers constitutionally protected entitlements which the Commonwealth has enacted as a matter of policy.

The right to invoke the supersedeas, or to stop payments, is a power that traditionally was held in the hands of the State. When insurance companies invoke the supersedeas (i.e., suspension) of an employee's medical benefits, they compromise an employee's State-created entitlements. The insurers have no power to deprive or terminate such benefits without the permission and participation of the Commonwealth. More importantly, however, the Commonwealth is intimately involved in any decision by an insurer to terminate an employee's constitutionally protected benefits because an insurer cannot suspend medical payments without first obtaining authorization from the Bureau. However this authorization may be characterized, any deprivation that occurs is predicated upon the State's involvement.

There is little difference between the approval required here and that necessary for utilizing a peremptory challenge, *see, e.g., Edmonson*, 500 U.S. at 622, or for employing a nonclaim statute

with the assistance of the probate court. *See, e.g., Tulsa Prof'l Collection Serv. v. Pope,* 485 U.S. 478 (1988). "The [Bureau] is intimately involved throughout, and without that involvement" the supersedeas could not operate. *Id.* at 487. Further, the supersedeas lacks the self-executing characteristic that might otherwise render due process concerns irrelevant. To the contrary, the supersedeas provisions at issue are not self-executing, and without the Commonwealth's involvement and approval, the insurance companies would be precluded from suspending medical benefit payments — an aspect of the Workmen's Compensation procedure which they had desired. Accordingly, we hold that the private insurance companies are state actors when they invoke the supersedeas provisions under § 531(5) and (6).

Our decision is consistent with *West v. Atkins,* 487 U.S. 42 (1988). There, the Court held that a private physician under contract with the State of North Carolina to provide medical services to prison inmates acted under color of state law even though the doctor was not directly employed by the State. In *West*, the State was under an affirmative obligation to provide medical care to inmates. The State delegated that responsibility to a part-time contract physician, who assumed the State's obligation. Under these circumstances, the Court held that state action attached to the actions of the private doctor such that the prisoner could maintain a § 1983 cause of action against the doctor.

That the doctor exercised professional judgment and discretion independent of the State was insufficient to relieve him of his constitutional obligations. *See id.* at 52. The Court emphasized that "[i]t is the physician's function within the state system, not the precise terms of his employment, that determines

whether his action can fairly be attributed to the State." *Id.* at 55-56. "[T]he dispositive issue concerns *the relationship among the State, the physician, and the prisoner.*" *Id.* at 56 (emphasis added).

Similarly, in this case, examining the relationship among the Commonwealth, employer, and the insurance companies, we have concluded that the actions of the insurers constitute state action. The employers are under an affirmative obligation to insure their employees for work-related accidents. This obligation is expressly assumed by the insurance companies when an employer purchases insurance, *see* 77 Pa. Const. Stat. Ann. §§ 501, 701, and is assumed by the Commonwealth if and when a insurer becomes insolvent.[19] Like the constitutional right involved in *West*, the employees under the Act have a constitutionally protected entitlement in receiving their Workers' Compensation medical benefits. In addition, like the prisoner in *West*, the employees cannot elect to go outside the system for medical treatment. Like prisoners, they are locked into the system, and any relief that the employees obtain is strictly through the program which the State has designed. The employees are, in essence, prisoners — albeit beneficiaries — of the Commonwealth's Workers' Compensation system.

Our conclusion is also consistent with the decision of the three-judge district court panel which convened in *Baksalary v. Smith*,[20] 579 F. Supp. 218 (E.D. Pa. 1984), which held that the

19. *See supra* note 17.

20. In *Baksalary*, a three-judge panel of the district court comprised of two district court judges and one Court of Appeals judge, convened pursuant to 28 U.S.C. § 2284. In *Baksalary*, employees contested an automatic supersedeas

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state action mantle falls upon the insurers. Baksalary involved a similar challenge to the Act, held that the insurers acted under color of state law, and accordingly found that there had been a denial of due process in violation of the Fourteenth Amendment from the invocation of section 413, 77 Pa. Const. Stat. Ann. § 774, a similar supersedeas provision.

We are aware that *Baksalary* has been criticized by the Fifth Circuit in *Barnes v. Legman*, 861 F.2d 1383 (8th Cir. 1988), but we do not share the Fifth Circuit's view. *Barnes* concerned a due process challenge to a provision in Texas' Workers' Compensation Statute that permitted an insurance carrier to terminate medical benefits based upon a medical report. As the *Barnes* decision is predicated upon its interpretation of Texas — as distinct from Pennsylvania — law, it is necessarily inapposite to this case. The *Barnes* court did not explain in detail the procedural involvement of Texas in permitting the insurance company to deny an employee his/her benefits. Clearly, however, the statutory provision permitting the termination of benefits in *Barnes* and the supersedeas provisions at issue here vary significantly. In *Barnes*, for instance, the insurance company was not compelled to resume the employee's benefits even after a State officer reviewing the case recommended that the insurance company reinstate those benefits. *See Barnes*, 861 F.2d at 1384. Thus, the employee was left with a cause of action under state law only.

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provision under the Act that terminated an employee's benefits without notice or a pre-termination opportunity to be heard. If an employer or insurer filed a petition which alleged that an employee had returned to work at the same or higher rate of pay, or if the petition — accompanied by a physician's affidavit — alleged that the employee had recovered from his/her disability, then the employer or insurer could terminate the employee's Workers' Compensation benefits. *See Baksalary*, 579 F. Supp. at 221.

In addition, it is unclear whether employers and/or employees can opt-out of Texas' Workers' Compensation scheme. In Pennsylvania, as we have stated, they cannot. Moreover, and perhaps most importantly, it is not clear that under Texas law that State involvement was required *prior* to the termination of benefits. *See* Tex. Workers' Compensation Law, art. 8307 § 11 (repealed 1989).[21]

Nor do we find other state action authorities to be persuasive in analyzing the context of Pennsylvania's Workmen's Compensation statutory scheme. As we have previously observed, the factual context in which the particular issue arises must be the focus of a state action inquiry. Other cases cited by the insurers such as *Blum v. Yaretsky*, 457 U.S. 991 (1982) (finding no state action when private nursing homes decided to transfer or discharge Medicaid patients without notice or a hearing), *Rendell-Baker v. Kohn,* 457 U.S. 830 (1982) (finding no state action when private school fired employees despite the fact that school was financed from almost exclusively public sources and was extensively regulated by government), *Flagg Brothers v. Brooks,* 436 U.S. 149 (1978) (finding no state action when private warehouseman invoked self-help provisions of New York's Uniform Commercial Code by selling goods entrusted to him),

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21. Article 8307, § 11, provides:

> Association suspending payments. When the association suspends or stops payment of compensation, it shall immediately notify the board of that fact, giving the board the name, number and style of the claim, the amount paid thereon, the date of the suspension or stopping of payment thereon, and the reason for such suspension or stopping.

Tex. Workers' Compensation Law, art. 8307, § 11 (repealed 1989).

and *Jackson v. Metropolitan Edison Company*, 419 U.S. 345 (1974) (finding no state action when privately owned electric utility terminated a customer's electric service for nonpayment without a hearing), do not, by the very nature of the controversies with which they dealt, involve a comprehensive statutory scheme similar to that present in this case.

We therefore conclude that, in the present context of a comprehensive state scheme reflected in the Workers' Compensation statute of Pennsylvania, the private insurers are state actors. The Act mandates compliance by employers, employees, and insurance companies and inextricably entangles the insurance companies in a partnership with the Commonwealth such that they become an integral part of the state in administering the statutory scheme. This relationship more than suffices to satisfy the constitutional requisites under the tests — varied though they may be — for state action. *See Blum*, 457 U.S. at 1004 (state action exists if the State has coerced the action or provided significant encouragement); *Rendell-Baker*, 457 U.S. at 842 (state action exists if there is a symbiotic relationship between the state and the private actor); *Flagg Bros.*, 436 U.S. at 157-59 (state action exists if private actor exercises powers exclusively within the prerogative of the State); *Jackson*, 419 U.S. at 351 (state action exists if a sufficiently close nexus between State and private actor is found); *Mark*, 51 F.3d at 1156 (suggesting courts should employ a totality of circumstances approach to state action inquiries) (Greenberg, J. concurring). We expressly limit our holding here today, however, to the unique context in which the instant supersedeas provisions arise.[22]

22. In light of our holding that the private insurance companies are state actors and are thus bound by the constraints of due process, we need not address the question as to whether a disparate classification concerning a public insurer, such as SWIF, and the private insurers would violate the Equal Protection Clause of the Fourteenth Amendment.

Appendix A

IV.

We now address the due process issue that is at the heart of the instant action.

The gravamen of Sullivan's complaint is that the lack of notice afforded under the supersedeas provisions, § 531(5) and (6), of the Act violates the procedural due process guarantees under the Fourteenth Amendment because neither the Initial Request for utilization review nor the Notice of Assignment specifically informs an employee that the insurer or employer can stop paying for the contested medical treatments pending review.[23] Although employees are notified that their employers or insurers have invoked the utilization review process pursuant to 34 Pa. Code § 127.452, or are notified that the case has been assigned for review to a URO, pursuant to 34 Pa. Code § 127.453(b), Sullivan points out that such notification does not provide any information or explanation concerning what the utilization review process involves. Sullivan also contends that neither notification provides any information about how an employee can contest the underlying allegations that serve the basis for the utilization review. Accordingly, Sullivan argues that such notification is defective because (1) the employee receives no notice that his/her benefits may cease pending review, (2) the employee receives no meaningful notice *prior* to the deprivation, and (3) the employee

23. Neither party disputes the district court's ruling that Workers' Compensation benefits are a constitutionally protected property interest subject to scrutiny under the Due Process Clause of the Fourteenth Amendment. *See, e.g., Sullivan* II at 4; *see also Baksalary v. Smith*, 579 F. Supp. 218, 224-25 (E.D. Pa. 1984) ("We find that when an individual must forego the use of his [workers'] compensation benefits for as long as one year . . . that individual has undergone the deprivation of a constitutionally protected property interest."). Accordingly, we concentrate upon whether the procedures afforded to employees under the Act comport with the strictures of due process.

is not advised of the procedures under which he/she can protest the imminent deprivation.

The Bureau does not dispute that no notice is provided to an employee that his/her medical benefits might be suspended. Rather, the Bureau contends that the decision to discontinue such benefits (i.e., request a supersedeas) is discretionary and is determined solely by the employer or the insurer, not the Bureau. Thus, the Bureau maintains that it does not have information regarding the status of an employees' medical benefits in a utilization review case, and accordingly it does not deny employees of procedural due process by failing to notify them of such information. The Bureau further asserts that this case is not akin to *Goldberg v. Kelly*, 397 U.S. 306, 314 (1970),[24] such that a pre-deprivation hearing is required prior to the suspension of medical benefits. As a result, the Bureau maintains that sufficient process is afforded to employees under the Act.

"The core of due process is the right to notice and a meaningful opportunity to be heard." *LaChance v. Erickson*, ___ U.S. ___, 1998 WL 17107 (1998) at 3; *see also Cleveland Bd. of Educ. v. Loudermill*, 470 U.S. 532, 542 (1985); *Memphis Light, Gas & Water Div. v. Craft*, 436 U.S. 1, 13 (1978); *Fuentes v. Shevin*, 407 U.S. 67, 80 (1972); *Mullane v. Central Hanover Bank & Trust Co.*, 339 U.S. 306, 313 (1950). We will thus address the constitutionality of the pre-deprivation notice the employees receive in this case and their opportunity to be heard, in turn.

A. Notice

"[A]dequate notice detailing the reasons for a proposed termination" of a constitutionally protected liberty or property

24. In *Goldberg v. Kelly*, the Supreme Court held that a pre-deprivation evidentiary hearing was required prior to the termination of welfare benefits.

interest must be afforded to individuals prior to the deprivation. *Goldberg v. Kelly*, 397 U.S. 254, 267-68 (1970). Notice must be "reasonably calculated, under all the circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections." *Mullane*, 339 U.S. at 314. The level of notice required before an individual is deprived of a constitutionally protected property interest depends upon the particular benefits at issue. "[D]ue process is flexible and calls for such procedural protections as the particular situation demands." *Morrissey v. Brewer*, 408 U.S. 471, 481 (1972).

In *Memphis Light, Gas & Water Division*, the Supreme Court held that a Memphis utility company did not provide constitutionally sufficient notice to its customers prior to terminating their utilities. Although the utility gave its customers notice that their service could be terminated for nonpayment of their bill, the company failed to inform its patrons of how they could protest or object to charges on their bills. The Court concluded that "[n]otice in a case of this kind does not comport with constitutional requirements when it does not advise the customer of the *availability of a procedure for protesting a proposed termination . . . as unjustified.*" 436 U.S. at 14-15 (emphasis added).

In *Goldberg v. Kelly*, the Court considered whether the notice provisions of New York City's welfare termination process comported with due process. As welfare recipients were given seven days advance notice of the impending termination, a letter informing them of the precise questions raised about their continued eligibility and the legal and factual bases for the Department of Social Services' doubts, and a personal conference explaining the same, the Court held that the notice provisions were adequate. *See* 397 U.S. at 268. Similarly, although

notice was not directly at issue in *Mathews v. Eldridge*, 424 U.S. 319, 324 (1976), the Court acknowledged that recipients of Social Security disability payments were afforded proper notice which included a letter informing them that their benefits would be terminated prior to the deprivation, a detailed explanation of the reasons for the proposed termination, and the opportunity to submit additional evidence to the agency making the determination prior to the actual deprivation.

Moreover, we held in *Ortiz v. Eichler*, 794 F.2d 889 (3d Cir. 1986), that the notice provided by Delaware prior to the termination or denial of Aid to Families with Dependent Children, Food Stamps, and Medicaid benefits was constitutionally deficient because it failed to explain the reasons for the state agency's action and did not contain the agency's specific calculations utilizing an employee's income or financial resources to ascertain his/her eligibility in making its determination. *See id.* at 892, 895.

The Supreme Court of Iowa confronted a similar problem to the one at hand when it considered the notice to which an employee was entitled before his/her Workers' Compensation benefits were terminated. There, the Court held that at a minimum due process required the following:

(1) the contemplated termination,

(2) that the termination of benefits was to occur at a specified time not less than 30 days after notice,

(3) the reason or reasons for the termination,

(4) that the recipient had the opportunity to submit any evidence or documents disputing or

contradicting the reasons given for termination, and, if such evidence or documents are submitted, to be advised whether termination is still contemplated,

(5) that the recipient had the right to petition for review.

Auxier v. Woodward State Hospital-School, 266 N.W.2d 139, 142-43 (Iowa 1978).

Informed by established precedent, we hold that in the case of terminating the medical benefits of a workers' compensation employee, at a minimum due process requires that employees receive notice that includes (1) timely notification that their medical benefits might cease prior to the deprivation, (2) an explanation of the reasons for the proposed termination, (3) an opportunity to respond to the accusations alleged, and (4) information advising them of the availability of the procedures that they may utilize to protest the proposed termination.

In the instant case, the notice that an employee receives prior to the termination of his/her medical benefits is constitutionally inadequate. While the employee is notified by the Initial Request that utilization review has been invoked and the reasons upon which the utilization review is based, the Initial Request does not explain that a supersedeas or suspension of one's medical benefits may result nor does it explain what utilization review entails. In addition, it does not inform an employee of any procedures under which the employee can protest the suspension of the medical benefits or contest the merits on which the proposed deprivation is based.

Similarly, the Notice of Assignment does not cure any of the above notice deficiencies. The Notice of Assignment is, in fact, a copy of the notice to the URO informing the URO that a particular case has been assigned. Like the Initial Request, the Notice of Assignment does not notify an employee that his/her medical benefits may be terminated nor does it advise an employee of any procedures under which such termination may be challenged. Further, by the time the Notice of Assignment is received, the employees' medical benefits may have already been suspended, as the supersedeas can be invoked and thus a suspension of benefits effected upon the proper filing of the utilization review process.

That an employee's medical benefits may be suspended prior to his/her receiving notice of that termination is constitutionally fatal to § 531(5) and (6) under the strictures of the Due Process Clause of the Fourteenth Amendment. *See Carey v. Piphus*, 435 U.S. 247, 259 (1978) ("Procedural due process rules are meant to protect persons not from the deprivation, but from the *mistaken* or *unjustified deprivation* of life, liberty, or property.") (emphasis added). At no time prior to the termination is the employee informed of any procedure under which he/she can dispute the supersedeas. As the employee is not informed of the deprivation of his/her medical benefits prior to its taking effect, inadequate notice effectively strips an employee of his/her ability or opportunity to protest or minimize unjustified deprivations.[25]

In *Baksalary v. Smith*, 579 F. Supp. 218, 233 (E.D. Pa. 1984), a three-judge panel of the district court held a similar supersedeas

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25. At oral argument, the Commonwealth conceded that no notice was afforded to the employees whose medical benefits were terminated pursuant to the supersedeas provisions at issue here. In addition, the Commonwealth recognized that providing notice would be "easy" to remedy.

provision unconstitutional where it failed to provide notice to the employee until after the benefits had already been terminated. Similarly, we conclude that § 531(5) and (6), the supersedeas provisions pertaining to utilization review of medical benefits, is unconstitutional because it fails to provide employees with adequate pre-termination notice.

Our invalidation of this supersedeas provision of the Act does not thereby annul other provisions of the Act:

> Under Pennsylvania law, separate provisions of a statute are presumed severable, and any particular one will survive a decision voiding another unless it is so interrelated with the void provision or incomplete without it that the legislature could not have intended it to stand alone.

Stoner v. Presbyterian Hosp., 609 F.2d 109, 112 (3d Cir. 1979) (citing 1 Pa. Const. Stat. Ann. § 1925). Thus, under our holding today we do no more than sever the "unless" clause from § 531(5) of the Act. We are thereby left with a statute that reads as follows and that requires employers or insurers to make payments in accordance with the provision of the Act, but that does not give those employers or insurers the discretion or opportunity to invoke the supersedeas of an employee's medical benefits:

> The employer or insurer shall make payment and providers shall submit bills and records in accordance with the provisions of this section. All payments to providers for treatment provided pursuant to this act shall be made within thirty (30) days of receipt of such bills and records.

Appendix A

B. Opportunity to be heard

Due process requires that "an individual be given an opportunity for a hearing before he is deprived of any significant property interest." *Boddie v. Connecticut*, 401 U.S. 371, 379 (1971) (emphasis in original). The right to be heard " 'must be granted at a meaningful time and in a meaningful manner.' " *Fuentes*, 407 U.S. at 80 (quoting *Armstrong v. Manzo*, 380 U.S. 545, 552 (1965)). While it is undisputed that some sort of hearing is required before an individual is finally deprived of a liberty or property interest, due process necessitates some sort of pre-termination opportunity to be heard regarding the basis of the proposed termination. *See Loudermill*, 470 U.S. at 542 ("Even decisions finding no constitutional violation in termination procedures have relied on the existence of some pre-termination opportunity to respond.") "The opportunity to present reasons, either in person or in writing, why proposed action should not be taken is a fundamental due process requirement." *Id.* at 546.

In the case before us, the employees were not given a pre-deprivation opportunity to respond to the proposed termination of their medical benefits. Indeed, as we have discussed above, they were not even given notice of the impending termination. "[The] right to be heard has little reality or worth unless one is informed that the matter is pending and can choose for himself whether to appear or default, acquiesce or contest." *Mullane*, 339 U.S. at 314. So, while the Commonwealth's statutory scheme provides that employees be given an opportunity for a *post-termination* evidentiary hearing in the form of a *de novo* hearing before an ALJ, we must address what *pre-termination* opportunity to be heard is required to satisfy the constitutional minimum of due process.

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In order to determine the extent of the pre-deprivation process, we must consider and balance the following factors:

> First, the private interest that will be affected by the official action. Second, the risk of erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute safeguards; and, finally, the government's interest including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirements would entail.

Mathews v. Eldridge, 424 U.S. 319, 334-35 (1976). We will deal with each factor in turn.

(1) Private Interest

The employees' interest is in the uninterrupted payment of their medical benefits pending the final administrative decision on their cases. *Sullivan II* at 5. As the district court acknowledged, this interest is "without a doubt[,] significant." *Id.* Without receiving her medical treatments, a concomitant of having her medical benefits paid to her medical provider, Sullivan alleges that she has endured longer periods of disability, unnecessary pain, and functional restriction. *See* Am. Compl.

Notwithstanding the employees' significant interest, the district court found that these interests were mitigated by several factors. First, the district court noted that, unlike *Goldberg*, termination of one's medical benefits would not deprive an employee of the very means of his/her subsistence. *See Sullivan II* at 5. The district court also concluded that the availability of full remedies mitigates the impact of the supersedeas. *Id.* at 6.

For instance, an employee whose medical benefits are reinstated on appeal by an ALJ is entitled to an award of benefits plus ten (10) percent interest. *See* 77 Pa. Const. Stat. Ann. § 717.1(a) (West Supp. 1997). In addition, the prevailing employee may recover the costs of litigating his/her right to medical benefits. *See id.* § 996 (West Supp. 1997).

Additionally, the district court noted — and the Defendants contend — that the Act does not proscribe a medical provider from continuing to treat an employee during the utilization review process. *Sullivan II* at 5 n.4. Indeed, in the amended complaint, some of the Plaintiffs admit to receiving some medical treatments although such treatments were undergoing utilization review. *See, e.g.*, App. A-107 (Louis Baumgartner). Further, there is nothing in the statute that requires that an employee's medical benefits be suspended. *See Sullivan II* at 8.

Finally, the Defendants emphasize that this case is unlike *Goldberg, Mathews*, and other traditional due process cases because the court must not only weigh the private interest of Sullivan against the governmental interest, but must also consider the conflicting private interest of the insurance companies. The insurers have an interest in not paying for unnecessary and/or unreasonable medical treatment. The Defendants argue this interest is significant because once such treatment is paid it cannot be recouped from employees or their medical providers even if the disputed treatment is found to be unreasonable or unnecessary. *See Moats v. Workmen's Compensation Appeal* Bd., 588 A.2d 116, 118 (1991) ("[T]he employer may not seek reimbursement from the claimant or be relieved of paying past medical bills."). Accordingly, the district court held that "a full evidentiary hearing prior to a possible temporary suspension of benefits is not an indispensable requisite for the process that is due." *Sullivan II* at 6.

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The district court mischaracterized the nature of Sullivan's interest, and in so doing, minimized the severity of the deprivation at issue. The district court apparently viewed the medical benefits as more akin to a pecuniary interest, and not an interest in the relief that the medical treatment provides to injured employees. The remedies that the Act provides to an employee whose medical benefits are unjustly terminated provide merely superficial redress as they focus upon a monetary interest as distinct from a medical interest in one's well-being. Further, as medical benefits are typically terminated upon invocation of utilization review, the employee does not receive any medical treatment pending review and thus there may be no medical costs to reimburse upon a determination that the medical treatments were, in fact, reasonable and necessary. Once the supersedeas is invoked, it can take several months before the URO reaches its decision and — before the reconsideration process was rescinded— even longer if reconsideration review was requested.[26] Although a monetary award may compensate an individual for financial losses, a monetary award cannot be deemed an adequate, effective, or appropriate substitute for relieving an employee's disability or pain. Nor can it be a substitute for necessary medical care. Hence, we are persuaded that the employees' private interest in receiving uninterrupted medical benefits is a weighty and significant factor in the pre-termination calculus.

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26. Although the URO is required to render a decision within thirty (30) days of the receipt of the employee's medical records or sixty (60) days from the date of assignment, in the amended complaint, Sullivan alleges that this time frame is often not adhered to. *See* Am. Compl. ¶ 66. The length of the deprivation here further supports our conclusion that the private interests are significant. *See Mathews*, 424 U.S. at 341 ("the possible length of wrongful deprivation of . . . benefits is an important factor in assessing the impact of official action on the private interests.") (internal quotations and citation omitted); *see, e.g., Baksalary*, 579 F. Supp at 224 (stating that resolution of case typically took one year or more).

(2) Risk of Erroneous Deprivation

The district court held that the risk of erroneous deprivation in the instant case was slight. The utilization review process considers only medical reports provided directly by the treating physician and related specifically to certain questioned medical procedures and treatments; no independent medical reports are consulted. The reviewer is a physician in the same profession and with the same specialty as the treating physician, and the reviewer is only permitted to apply generally accepted medical protocols to determine whether the questioned treatment is reasonable or necessary. The district court acknowledged — and Defendants argue — that medical reports are unbiased, objective, and trustworthy, and thus, the problems associated with credibility of witnesses are not present such that a pre-deprivation hearing would be helpful. In addition, as reconsideration review has been eliminated by Act 57, an employee can receive a *de novo* evidentiary hearing before an ALJ more quickly than before.[27] As a result, the district court held that additional safeguards were not necessary to protect an injured employee from being deprived of one's constitutionally protected property interest in receiving medical benefits. We disagree.

Contrary to the district court's conclusions, we believe that the risk of erroneous deprivation is significant and that additional safeguards can meaningfully minimize the risk of wrongful termination of one's medical benefits. As we stated above, employees receive no notice that a supersedeas of their medical benefits will likely result upon the invocation of utilization review.

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27. Most of the Plaintiffs before us were subjected to the reconsideration review process as the termination of their medical benefits occurred prior to the amendment to the Act. *See* Am. Compl. ¶¶ 102, 105, 129, 163, 181, 198, 216, 254.

They are given no pre-deprivation opportunity to be heard either in writing or in person; they are not advised of how they can protest or dispute the underlying allegations that their medical treatments are unreasonable or unnecessary. Although the employee's physician must be given an opportunity to discuss the employee's treatment, *see* 34 Pa. Code § 127.469, we are hard-pressed to believe that the portrait of the employee's illness and treatment is complete without a statement or other input from the employee himself.

The district court seems to have equated the teaching of Mathews that an evidentiary hearing is not necessarily required prior to the deprivation of a constitutionally protected interest with the notion that no pre-termination process need be afforded at all. We have come to a different conclusion. Due process dictates that employees have some sort of pre-deprivation opportunity to respond before the supersedeas takes effect so as to guard against an erroneous deprivation of benefits.

(3) Governmental Interest

The governmental interest that must be considered is ensuring that only truly disabled individuals are receiving reasonable and necessary medical treatment. *Sullivan II* at 8. The government also has an interest in containing the rising costs of medical care and insurance payments. Indeed, cost containment is the purpose behind the supersedeas provisions in question here. Further, the government has an interest in conserving its scarce fiscal and administrative resources, and an increase in pre-deprivation procedures may well be an added burden upon those resources. While we agree that such legitimate interests exist, we are also aware that the government has an interest in not wrongfully depriving medical benefits to disabled individuals and ensuring

that employees who reasonably and legitimately need medical care under the Act will continue to receive it. On balance, therefore, we are not convinced that any governmental interest outweighs the private interest we have discussed above and which favors Sullivan. Thus, we conclude that the denial of any pre-deprivation process cannot be sustained.

C. What Process is Due

Now that we have weighed the three factors under the *Mathews* analysis, and concluded that § 531(5) and (6) do not adequately suffice to protect Sullivan's due process interests, we must decide how much process to afford employees receiving medical benefits under the Act prior to the termination of such benefits.

In only one case, *Goldberg v. Kelly*, 397 U.S. 306 (1970), which involved subsistence welfare benefits, has the Court required a full evidentiary hearing prior to the deprivation. In contrast, in *Mathews*, the Court concluded that an evidentiary hearing was not necessary before an individual was deprived of his/her Social Security benefits because, unlike the welfare benefits at issue in *Goldberg*, the disability payments were less likely to be the individual's sole source of income. The Court held that notice of the proposed reasons for the termination and advice as to how the recipient could obtain and submit additional information prior to the termination was sufficient to comport with pre-deprivation due process procedure. Similarly, in *Loudermill*, the Supreme Court determined that due process required that a tenured public employee be given oral or written notice of the charges against him/her, an explanation of the employer's evidence, and an opportunity to present her position prior to termination of her position. *See* 470 U.S. at 546.

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While we believe that additional procedural safeguards will cure the problems currently at issue with the supersedeas provisions, due process does not require a *Goldberg*-style evidentiary hearing prior to the deprivation of medical benefits. Utilization review is premised upon "routine, standard, and unbiased medical reports," *Mathews*, 424 U.S. at 344 (quoting *Richardson v. Perales*, 402 U.S. 389, 404 (1971)), from the treating physician, reviewed by a physician in the same specialty who assesses the case based upon generally accepted medical protocols, principles, and practices. Issues of credibility and veracity are less likely to be an issue in such a case. Accordingly, the potential benefit of a pre-termination evidentiary hearing — or even an oral presentation to the medical reviewer — is substantially less in this context than in a *Goldberg*-context. *See, e.g., Mathews*, 424 U.S. at 344-45.

Nevertheless, we think that at a minimum the employee should be granted the opportunity to present additional evidence such as his/her personal testimony in writing as to the reasonableness and necessity of the disputed treatment, as this could significantly lessen the risk of erroneously depriving an employee of his/her medical benefits. This may be particularly true for the recipient of unorthodox, naturopathic, or non-traditional medical treatments — such as, for example, acupuncture or chiropractic manipulation. Without some sort of indication from the very individual who is receiving the questioned medical treatment as to its success or the employee's improvement, the risk of erroneously terminating an employee's medical benefits is too high.

We are ever mindful of the fact that the supersedeas provision contested in this case applies only to *disabled* workers who may experience chronic pains over the course of several years. Many of these workers may be disabled for life. The personal written submission of such disabled workers is critical to assessing the

relative benefits that a particular treatment or practice might have. While reading medical reports and reviewing patients' charts might appear to show relatively slight improvement, suggesting that the medical treatment is unreasonable or unnecessary, a particular treatment might be the only medical treatment that alleviates an individual's pain or mitigates the severity of his/her symptoms. As the utilization review process concerns itself only with the specific medical practice that is being challenged, *see* 34 Pa. Code § 127.470, the reviewing physician may have little or no perspective as to how a particular treatment is benefitting the patient in the context of the overall medical care that the employee has undergone during the course of his/her disability.[28] The opportunity for the employee to present his/her side of the story — to introduce his/her own personal account as to how the particular treatment has ameliorated his/her condition — may be highly relevant to the URO's determination and may not be adequately reflected or documented in the medical reports.

Cognizant of the governmental interest, we believe that this additional procedural safeguard of permitting an employee to submit his/her personal account in writing of the reasonableness or necessity of the disputed medical treatment would not prove unduly onerous or administratively burdensome or costly to implement. To the contrary, the present procedures could remain intact but with the exception that the employee be notified at a meaningful time and in a meaningful manner (prior to the termination of his/her medical benefits) that he/she can submit, if

28. While we recognize that the regulations require that a URO attempt to obtain a complete set of medical records from all of an employee's medical providers for a particular injury, *see* 34 Pa. Code. § 127.462, there is no guarantee that all of an employee's records will be located, received, and reviewed during the utilization review. In any event, medical records provide but one component for consideration before an employee is deprived of his/her constitutionally protected interest in his/her medical benefits.

he/she so chooses, a letter or a statement to the URO regarding the reasonableness or necessity of his/her medical treatment. The reviewing physician could then consider the employee's account as part of the evidence considered when making his/her determination. We are not persuaded that this type of evidence would pose a problem for the reviewing physician, as doctors regularly make judgments about the course of treatments depending upon the input from their patients. The reviewing physician as part of the utilization review process would simply consider the employee's account of the medical treatment before rendering judgment.

In sum, we hold that the supersedeas provisions under § 531(5) and (6) violate the dictates of due process by not affording disabled employees notice or an opportunity to be heard before their medical benefits are suspended. To remedy the procedural defects in the statute, at a minimum, an employee must be given: (1) timely and reasonable notice of the imminent suspension of the medical benefits and treatment before the suspension takes effect; (2) a description of the reasons why utilization review has been invoked; (3) an opportunity and time to submit a personal statement in writing regarding the employee's view of the reasonableness and/or necessity of the disputed medical treatments; and (4) a description of the procedures under which the employee can appeal an adverse determination.

V.

In addition to the deficiencies we have discussed regarding the Commonwealth's statutes, we now consider whether the regulations governing utilization review provide adequate guidance to UROs and ALJs. We hold that they do.

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Sullivan claims that the regulations governing utilization review fail to provide standards for determining whether the contested medical treatment is reasonable or necessary. Without such standards, Sullivan contends that the decisions by the UROs and ALJs are *ad hoc*, arbitrary, and without any consistency among the various UROs or ALJs such that those decisions violate her right to procedural due process under the Fourteenth Amendment. We cannot agree.

The district court properly held that the regulations in question provide sufficient guidance to reviewing physicians and ALJs to comport with due process. As in any case that is subject to utilization review, the inquiry solely focuses upon whether the medical treatment in question is reasonable and/or necessary. *See* 34 Pa. Code § 127.470. In so doing, the regulations provide that the reviewing physician must be of the same specialty as the treating physician, *see* 77 Pa. Const. Stat. Ann. § 531(6)(i), and that the reviewer must analyze the disputed treatment in light of generally accepted medical protocols. *See* 34 Pa. Code § 127.467. The reviewing physician may not consider whether the injury being treated is work-related, whether the employee continues to be disabled, whether the employee has reached maximum medical improvement, or whether the fees assessed for the services provided are reasonable. *See id.* § 127.470. Furthermore, the reviewer must provide a detailed opinion in writing that explains the basis for his/her determination. *See id.* § 127.472. Accordingly, the regulations provide guidelines which serve to provide necessary guidance to the reviewing physician concerning the appropriate bases for his/her determination such that the ultimate determinations are not arbitrary and do not discriminate.

Similarly, the *de novo* hearings before Workers' Compensation ALJs also comport with due process. As in any

administrative hearing, the ALJ hears testimony, considers evidence, and renders decisions consistent with the applicable law. At these *de novo* hearings, an employee has the opportunity to present his/her own medical expert, the right to cross-examination of the witnesses, and the right to present additional evidence to support his/her claim. Further, the statute provides that the ALJ shall consider — but is not bound by — the report from the utilization review. *See* 77 Pa. Const. Stat. Ann. § 531(6)(iv). There is no indication that the *de novo* hearings in the utilization review context suffer from any different procedure or lack of guidance than any other administrative hearing of which we are aware. Accordingly, we hold that the regulations provide sufficient guidance to the reviewing physicians and the ALJs in evaluating employees' cases such that the employees' rights to procedural due process are honored.

VI.

We now address whether imposing the costs of reconsideration review upon a losing employee — without giving him/her proper notice beforehand — violates due process.

Before the amendments in Act 57, if either party disagreed with the decision rendered by the URO, that party could petition the Bureau for reconsideration review within thirty (30) days of receiving the decision. *See* 34 Pa. Code § 127.502(a). Unlike the initial utilization review, however, where the employer or insurer paid for the review, the Bureau advanced the costs of reconsideration review and charged the losing party for the cost thereafter. While Act 57 eliminated reconsideration review, Act 57 did not become effective until August 23, 1996, nearly three months after the amended complaint in this action was filed. Thus, most of the Plaintiffs before us were subjected to the costs of

reconsideration review when they suffered an adverse decision upon reconsideration. It is unclear from the undeveloped record below, however, whether any of the Plaintiffs actually paid these reconsideration fees.

Sullivan contends that the imposition of a fee upon a losing employee violated an employee's right to due process because such a fee was imposed without any notice, without an opportunity to be heard on the underlying contested claim, and without any consideration for the employee's ability to pay. There was no *in forma pauperis* status for reconsideration. Sullivan further asserts that such a scheme violated the liberty interests of employees because one may have foregone reconsideration review rather than risk paying the substantial costs of reconsideration if he/she lost.[29]

We do not decide whether the imposition of costs on reconsideration without notice violated the dictates of due process. As the Act has been amended, reconsideration review no longer exists, these fees are no longer imposed, and thus, this is not a continuing problem. Further, given the undeveloped record, we cannot determine whether any of the Plaintiffs, in fact, paid these fees. Accordingly, we remand to the district court to determine whether any of the Plaintiffs paid the costs of reconsideration, what those costs were, and to re-examine the possible constitutional difficulties that the imposition of reconsideration fees poses.

VII.

At this juncture, we raise an Eleventh Amendment sovereign immunity issue *sua sponte* as it is relevant to our jurisdiction

29. The costs of reconsideration review varies. The typical charge is several hundred dollars. *See* Am. Compl. ¶ 77.

over the Commonwealth Defendants. *See V-1 Oil Co. v. Utah State Dep't of Pub. Safety*, 131 F.3d 1415, 1419 (10th Cir. 1997) (raising Eleventh Amendment sovereign immunity *sua sponte*); *Suarez Corp. Indus. v. McGraw*, 125 F.3d 222, 227 (4th Cir. 1997) ("We believe that, because of its jurisdictional nature, a court ought to consider the issue of Eleventh Amendment immunity at any time, even *sua sponte*."); *Atlantic Healthcare Benefits Trust v. Goggins*, 2 F.3d 1, 4 (2d Cir. 1993) (raising Eleventh Amendment issue *sua sponte*); *Charley's Taxi Radio Dispatch Corp. v. Sida of Hawaii, Inc.*, 810 F.2d 869, 873 n.2 (9th Cir. 1987) (same); but *see Bouchard Transp. Co. v. Florida Dep't of Envtl. Protection*, 91 F.3d 1445, 1448 (11th Cir. 1996) (stating that the "Eleventh Amendment is not jurisdictional in the sense that courts must address the issue *sua sponte*").

The Eleventh Amendment[30] confers sovereign immunity upon the States such that they cannot be subject to suit in district court absent either Congressional intent to abrogate that immunity enacted pursuant to a valid exercise of power, *see Seminole Tribe v. Florida*, __ U.S. __, 116 S. Ct. 1114, 1123 (1996), or a State's explicit consent. *See Port Auth. Trans-Hudson Corp. v. Feeney*, 495 U.S. 299, 304 (1990). The Eleventh Amendment, however, does not immunize State officials for actions taken in their individual capacities. *See Scheur v. Rhodes*, 416 U.S. 232, 237-38 (1974).

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30. The Eleventh Amendment provides:

> The Judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of United States by Citizens of another State, or by Citizens or Subjects of any Foreign State.

U.S. Const. amend. XI.

Appendix A

The amended complaint does not make clear whether the Plaintiffs have brought suit against the Commonwealth Defendants in their official or individual capacities, or both.

We leave this for the district court to decide. If the district court determines that the Commonwealth Defendants have only been sued in their official capacities, the district court — in its discretion — may allow the Plaintiffs to amend their complaint to include those Defendants in their individual capacities. In any event, the district court will be obliged to address whether redress can be sought against the Commonwealth Defendants in federal court under Eleventh Amendment proscriptions.

VIII.

In conclusion, we hold that the supersedeas provisions of 77 Pa. Const. Stat. Ann. § 531(5) and (6), are unconstitutional in that they violate an employee's procedural due process rights by failing to provide adequate notice that his/her medical benefits may be suspended upon the invocation of utilization review and by not granting the employee an opportunity to respond in writing before that termination takes effect. We also hold that the private insurance companies are state actors and thus may be joined in a § 1983 action when they elect to invoke the supersedeas provisions to terminate or suspend an employee's constitutionally protected interests in receiving medical benefits.

Thus, we will reverse the order of the district court dismissing Sullivan's complaint and will remand to the district court for further proceedings in accordance with this opinion. On remand, among other issues, the district court should address the issue of reconsideration fees, the question of certifying a class, and for the first time, it should consider whether it has subject matter

jurisdiction over the Commonwealth Defendants in light of Eleventh Amendment sovereign immunity.

A True Copy:

Teste:

Clerk of the United States Court of Appeals
for the Third Circuit

APPENDIX B — ORDER OF THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA FILED DECEMBER 13, 1996

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

CIVIL ACTION
NO. 95-CV-201

DELORES SCOTT SULLIVAN, et al.,

Plaintiffs

v.

JOHNNY J. BUTLER, et al.

Defendants

ORDER

And now, this 13 day of December 1996, upon consideration of the School District of Philadelphia's Motion for Judgment on Plaintiffs' Amended Complaint, it is hereby ORDERED and DECREED that said Motion is GRANTED and the Amended Complaint is DISMISSED as to defendant School District of Philadelphia.

BY THE COURT:

s/ Ronald L. Buckwalter
RONALD L. BUCKWALTER, J.

APPENDIX C — MEMORANDUM AND ORDER OF THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA FILED NOVEMBER 7, 1996

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

CIVIL ACTION

NO. 95-201

DELORES SCOTT SULLIVAN, *et al.*,

Plaintiffs,

v.

JOHNNY J. BUTLER, *et al.*

Defendants.

MEMORANDUM

BUCKWALTER, J. November 7, 1996

I. INTRODUCTION

Plaintiffs in this putative civil rights action claim to be persons who had been receiving medical benefits pursuant to the Pennsylvania Workers' Compensation Law and who were thereafter deprived of those benefits without prior notice or an opportunity to be heard pursuant to the utilization review in Sections 306(f.1)(5) and (6) of the aforesaid law.

Appendix C

Presently before the Court for disposition are the Motion to Dismiss by defendants Johnny J. Butler, Richard A. Himler, Linda Kaiser, Catherine Baker Knoll and Ralph Chase ("Commonwealth Officials'') and plaintiffs' response thereto. For the reasons stated below, the Commonwealth Officials' motion is granted.

II. BACKGROUND

This background is gleaned from plaintiffs, Amended Complaint and matters of record, i.e., statutes, bulletins, etc.,

The Pennsylvania Workers' Compensation Act of June 2, 1915, P.L. 726, as amended, 77 P.S. § 1 *et seq.* (Supp. 1993) (hereinafter referred to as "the Act"), is a statute of statewide applicability. Its purpose is to substitute a state-regulated insurance system which provides reasonable compensation to employees for injuries arising in the course of their employment for the common law rights and liabilities of employers and employees.

The Act requires employers to obtain insurance or seek permission from the state to self-insure, so as to guarantee the availability of sufficient funds to pay eligible workers benefits pursuant to a statutory formula. Employers who do not self-insure may insure the payment of workers' compensation benefits with the Commonwealth-administered State Workers' Insurance Fund ("SWIF"), or with any other insurance company or mutual association authorized to insure such liability in the Commonwealth. The SWIF is required to insure all risks including those rejected or cancelled by private carriers.

On July 2, 1993, the Pennsylvania Legislature passed Act 44 which contained several amendments to the Pennsylvania

Workers, Compensation Act. It became effective on August 31, 1993. Act 44 contains provisions, now known as Sections 306(f.1)(5) and (6), for utilization review of the reasonableness and necessity of medical treatment.[1] Pursuant to Sections 306(f.1)(5) and (6), an insurer or self-insured employer may seek utilization review of the reasonableness and necessity of current, prospective or retroactive medical treatment. To request utilization review, the employer or insurer must file a petition with the Bureau of Worker's Compensation ("Bureau") on a form which the Bureau designed and approved.

The Bureau screens all petitions for utilization review for conformity with Sections 306(f.1)(5) and (6) and assigns each petition to a Utilization Review Organization ("URO") certified by the Pennsylvania Department of Labor and Industry. If the Bureau finds that a petition is not in conformity with the relevant sections, the Bureau returns it to the petitioner with specific instructions. *Id.*

At the time of the assignment to the URO, the Bureau forwards a Notice of Assignment to the employee, the employer or insurer and the provider of the medical treatment under review. At this point, the employer or insurer may suspend payment for the challenged treatment. Neither the Request for Utilization Review or the Notice of Assignment specifically notify the employee that the insurer or employer may stop payment of the contested medical treatment pending the review.

During the hearing before the URO, only the medical provider may discuss the challenged treatment. The employee or his or her

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1. The relevant portions of these sections are quoted at length in the Court's memorandum filed on January 24, 1996.

counsel may not testify before the URO or submit evidence supporting the employees claim for benefits. Additionally, the Bureau does not specifically define the terms "reasonable and necessary", thus leaving the construction of the standard to be applied to the discretion of the individual URO's.

Until Act 1996-57 became effective on August 23, 1996, the party dissatisfied with the outcome of this initial utilization review would file for reconsideration with the Bureau on a form prepared by the Bureau within thirty days of the initial decision.[2] The Bureau would then review the form for compliance with the statute and assign the case to another URO.

Under this old system, if the employer requested reconsideration, the supersedeas of the employee's medical benefits remained in effect even if the employee received a favorable decision from the initial URO. Although the employee received a copy of the insurer's or employer's Request for Reconsideration and a copy of the Notice of Assignment issued by the Bureau, neither document specifically notified the employee that the employer or insurer could suspend payment of the contested medical treatment throughout the pendency of the reconsideration.

Like in the first hearing before the URO, the provider of medical services could discuss the treatment under review, but the employee or his or her counsel was not allowed to testify or to submit evidence.

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2. Plaintiffs' claims surrounding this reconsideration step are not moot as two of the Plaintiffs sought reconsideration of the initial decisions in their cases and were unsuccessful. Therefore, Plaintiffs' claims present a live controversy. *See* Commonwealth Officials' Supplemental Brief In Support Of Motion To Dismiss at 4; Plamtiffs' Response to Commonwealth Officials' Motion to Dismiss at 3.

Appendix C

An employee who sought reconsideration unsuccessfully was liable for the payment of the URO's expenses. Likewise, if the employer or insurer sought reconsideration of an initial utilization review decision which was favorable to the employee, and the decision was reversed on reconsideration, the employee was liable for the payment of the URO's expenses.

Neither the Request for Reconsideration or the Notice of Assignment notified the employee that he or she would be liable for the URO's expenses if he or she did not prevail on reconsideration. Additionally, the Bureau did not fix the cost of the utilization review at the reconsideration level but left it to the discretion of the individual URO. There was no forma pauperis procedure to excuse the indigent employees from the assessment of the reconsideration fee. Finally, the URO assessed the fee against the employee as the losing party without any opportunity for the employee or his or her counsel to testify to the reasonableness and necessity of the medical treatment under review.

In the event a party was dissatisfied with the URO decision on reconsideration, he or she could file a Petition for Review with the Bureau on a form prepared by the Bureau. If the claimant prevailed on reconsideration, the supersedeas was lifted even if the employer or insurer filed a Petition for Review. If the claimant was unsuccessful, the supersedeas remained in effect.

The Bureau then reviewed all Petitions for Review for compliance with the statute and assigned the Petitions to a Workers' Compensation Judge for a *de novo* hearing. Proceedings before a Workers' Compensation Judge could extend for several months and claimants could await a decision for several months or even years.

Appendix C

Under Act 1996-57, the entire utilization review process is streamlined by the elimination of this reconsideration step. Therefore, after the initial URO issues its decision, a dissatisfied party may not seek reconsideration by another utilization review organization, as it could under the old system.

Instead, the party may petition for review of the initial URO decision by filing a Petition for Review with the Bureau on a form prepared by the Bureau. The Bureau then reviews all Petitions for Review for compliance with the statute and assigns the Petitions directly to a Workers' Compensation Judge for a *de novo* hearing. If upon receipt of the notice of assignment to a URO the insurer had decided not to pay bills, it would now have to pay bills submitted for treatment if the initial URO determination concludes that the treatment reviewed was reasonable and necessary. *See Pa. Bulletin*, Vol. 26, No. 33, p. 3980 (Aug. 17, 1996).

The Bureau has promulgated no regulations setting forth how Workers' Compensation Judges are to handle Petitions for Review on the following procedures: who has the burden of proof, what evidence will be allowed, the type and extent of hearing provided, whether the utilization reviewer may testify, whether the claimant must undergo medical examination and whether the parties may take depositions.

III. DISCUSSION

A. *Standard on Motion to Dismiss*

The purpose of a motion to dismiss under Federal Rules of Civil Procedure 12(b)(6) is to test the legal sufficiency of a complaint. *Sturm v. Clark*, 835 F.2d 1009, 1011 (3d Cir. 1987). A complaint may be dismissed for failure to state a claim upon which

relief may be granted if the facts plead and reasonable inferences therefrom are legally insufficient to support the relief requested. *Commonwealth ex. rel. Zimmerman v. PepsiCo, Inc.*, 836 F.2d 173, 179 (3d Cir. 1988). In reviewing a motion to dismiss, all allegations in the complaint and all reasonable inferences that can be drawn therefrom must be accepted as true and viewed in the light most favorable to the nonmoving party. *Wisniewski v. Johns-Manville Corp.*, 759 F.2d 271, 273 (3d Cir. 1985).

As due process is a question of law and not of fact, this is a proper question for a court decide in a motion to dismiss *Midnight Sessions, Ltd. v. City of Philadelphia*, 945 F. 2d 667, 682-83 (3d Cir. 1991), *cert. denied*, 503 U.S. 984 (1992). This is particularly appropriate in the current case as the interests at stake and the procedures at issue are evident from the Workers' Compensation Act and its regulations. *See Mathews v. Eldridge*, 424 U.S. 319, 335-340 (1976)(the court relied on the Social Security Act and its regulations in analyzing both the issues at stake and the reliability of the procedure in place).

B. *Automatic Supersedeas*

In Counts I and II of the Complaint, plaintiffs claim that (1) the automatic supersedeas contained in Section 306(f.1)(5) violates plaintiffs' right to procedural due process and (2) Sections 306(f.1)(5) and (6) do not provide the plaintiffs the opportunity to be heard at a meaningful time in violation of their right to procedural due process.[3]

3. In Count VI of the Complaint, plaintiffs allege that the deprivation of medical benefits authorized by Sections 306(f.l)(5) and (6) deprive Plaintiffs of liberty without due process of the law. Neither the plaintiffs or the Commonwealth Officials specifically address this claim, but the discussion of due process hereafter encompasses both the property and liberty interest.

Appendix C

In support of their motion to dismiss, the Commonwealth Officials make several arguments including: (1) that the due process clause does not prohibit the Commonwealth from allowing private insurers to suspend payment for medical treatments pending determination of their liability to pay for those treatments and (2) that the utilization review procedures afford employees adequate procedures regardless of whether they are invoked by private insurers or by the SWIF.

A claim under section 1983 alleging a violation of the due process clause of the Fourteenth Amendment requires proof of three elements. First, a section 1983 claimant must show a deprivation of a constitutionally protected liberty or property interest. *Baksalary v. Smith* 579 F. Supp. 218, 224 (E.D. Pa. 1984). Second, the claimant must show that the method by which the deprivation was effectuated involved a denial of due process. *Id.* Third, the claimant must show that the deprivation was accomplished under state law and as a result of state action. *Id.* With this standard in mind, the Court will address the Commonwealth Officials' arguments separately.

1. Deprivation

As discussed in a previous portion of this opinion, the Workers' Compensation Act permits an employer or insurer to challenge the reasonableness and necessity of an employees medical treatment by submitting a request to the Bureau of Workers' Compensation. The Bureau then assigns the request to a Utilization Review Organization ("URO"). At this point, the employer or insurer may suspend payment for the challenged treatment.

Upon review, the reviewer may, of course, determine that the treatment is unreasonable and unnecessary for the medical

condition of the employee. However, the reviewer may also determine that the opposite is true. If either side is then dissatisfied with the result, the party may appeal to the Bureau for a *de novo* hearing in front of a Worker's Compensation Judge.

In light of these facts, the Court must determine whether the plaintiffs are deprived of a constitutionally protected property interest when they must forgo the use of their workers' compensation medical benefits during the utilization review process. I hold that they are deprived of a constitutionally protected property interest.

This decision is supported by a long line of case law. In a similar case involving the termination of Social Security disability benefits pending a final hearing, the Supreme Court stated that it "has been implicit in our prior decisions . . . that the interest of an individual in continued receipt of these benefits is a statutorily created 'property' interest. . . . " *Mathews*, 424 U.S. at 332 (citations omitted).

More recently in *Baksalary v. Smith*, the United States District Court for the Eastern District of Pennsylvania extended *Mathews* and held that the right to receive workers' compensation benefits is also a property interest. 579 F. Supp. 218, 225 (E.D. Pa. 1984). As a result of these decisions, the Court concludes that the plaintiffs have undergone the deprivation of a constitutionally protected property interest when they are deprived even for a short time of their workers' compensation medical benefits.

2. **Due Process**

Having decided that the medical benefits termination under the Workers' Compensation Act must comply with the Fourteenth

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Amendment, the Court must now consider whether the Act accords plaintiffs sufficient process to constitute due process. *Baksalary*, 579 F. Supp. at 232 (citing *Perri v. Avech*, 724 F.2d 362, 366 (3d Cir. 1983)). I conclude that it does.

In *Goldberg v. Kelly*, 397 U.S. 254, 266-71 (1970), the Supreme Court concluded that the respective state agencies may not terminate a claimant's welfare payments without first affording the claimant a hearing. However, in *Mathews v. Eldridge*, 424 U.S. 305 (1976), the Court declined to extend the holding in *Goldberg* to cover Social Security disability benefit claimants.

The Court in *Mathews* distinguished *Goldberg* as having been based on welfare recipients' extreme financial need and concluded that since eligibility for disability benefits is not based on need and since the beneficiaries might have other means of subsistence, the claimants were not entitled to a pretermination hearing. *Mathews*, 424 U.S. at 340-41.

On these grounds, this case is similar to *Mathews*. As with Social Security disability benefits, an employee's eligibility for medical benefits under the Workers' Compensation Act is based on factors other than financial need. Additionally, the injured employee may have other sources of income, including the right to receive wage replacement.

Mathews sets forth the following criteria to determine if a particular system comports with due process (1) the private interest that will be affected by the action, (2) the risk that the procedures will result in an erroneous deprivation of the interest and (3) the governmental interest, including the function involved and fiscal and administrative burdens that the additional or substitute requirement would entail. *Mathews*, 424 U.S. at 335.

Appendix C

a. **Private Interests**

Since the plaintiffs whose medical benefits are terminated receive full retroactive relief, the private interest at stake here is the plaintiffs' desire for uninterrupted receipt of this benefit pending the final administrative decision on their cases. *See Mathews*, 424 U.S. at 340 (recipients of Social Security disability benefits sole interest is in uninterrupted receipt of this source of income as full relief may be awarded).

The plaintiffs' interest in this case is without a doubt significant. However, several factors exist which protect plaintiffs' interest. First, eligibility for workers' compensation medical benefits is not based on financial need. Therefore, termination of this aid pending resolution of the controversy will not deprive the plaintiffs of the very means by which they live. *See Mathews*, 424 U.S. at 340 (citations omitted). Moreover, the plaintiffs may have access to additional income sources such as wage replacement. *See Mathews*, 424 U.S. at 341-42 (claimants may have support from many other sources, "such as earnings of other family members, workmen's compensation awards, tort claim awards, savings, private insurance, public or private pensions, veterans, benefits, food stamps, public assistance. . . .).[4]

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4. Plaintiffs imply that these additional financial resources are inconsequential to this action because, under the unique circumstances of the Workers' Compensation Act, the provider cannot seek the payment for the challenged treatment from the employee. *Plaintiffs' Response* at 16. *See also* 77 P.S. §531(7) (Purdon's Supp. 1996).

Although the hardship imposed on the employee whose medical benefits are erroneously suspended is significant, Plaintiffs are still not

(Cont'd)

Additionally, the availability of full remedies lessens the potential harm to the individual employees and therefore protects their interests. *See Cryder v. Oxendine,* 24 F.3d 175, 178 (11th Cir. 1994)(because Georgia's Workers' Compensation Act provides full retroactive relief, the potential harm to the individual employee is less).

In this case, the injured employee has the benefit of the following remedies. An employee, who appeals from an adverse URO decision and then prevails before a Workers' Compensation Judge, is entitled to an award of benefits due plus 10% interest. 77 P.S. §717.1 (a) (Purdon's Supp. 1996). Additionally, the prevailing employee at this level may also recover the costs of the litigation. 77 P.S. §996 (Purdon's Supp. 1996). I do not wish to deprecate the employee's interest in the timely receipt of medical benefits, but when considering the nature of that interest as described in this memorandum, I believe it is adequately protected by the procedures in place. That is, a full evidentiary hearing prior to a possible temporary suspension of benefits is not an indispensable requisite for the process that is due, for reasons that follow in "b."

(Cont'd)

without recourse. First, nothing in the statute indicates that a claimant is prohibited from reimbursing the medical provider when the administrative process is concluded. Additionally, nothing in the statute even requires that the medical provider stop giving the challenged treatment.

When faced with similar concerns, the Court in *Mathews* still held that "[i]n view of these potential sources of temporary income [private resources and government assistance], there is less reason here than in *Goldberg* to depart from our ordinary principle, established by our decisions, that something less than an evidentiary hearing sufficient prior to adverse administrative action." 424 U.S. at 343.

b. Risk of Erroneous Deprivation

The plaintiffs contend that they are not given adequate notice that their medical benefits will be suspended through the utilization review process and are not provided with an opportunity to be heard at a meaningful time in a meaningful manner, thereby resulting in the risk of erroneous deprivation. The plaintiffs specifically argue that their due process rights are violated because they are not entitled to present evidence directly to the reviewers at the first step in the process.

In *Mathews*, the claimant had the benefit of the following procedures:

> [w]henever the agency's tentative assessment of the beneficiary's condition differs from his own assessment, the beneficiary is informed that benefits may be terminated, provided a summary of the evidence upon which the proposed determination to terminate is based and afforded an opportunity to review the medical reports and other evidence in his case file. He may also respond in writing and submit additional evidence.

424 U.S. at 337-38.

With these procedures in mind, the Supreme Court concluded that disability insurance recipients threatened with a loss of benefits were accorded a sufficient pretermination process, even though that process did not include a formal evidentiary hearing, so that an evidentiary hearing could be postponed until after termination. The procedures upheld in *Mathews* were regarded by the Court as "provid[ing] the claimant

with an effective process of asserting his claim prior to any administrative action....' 424 U.S. at 349.

The Pennsylvania Workers' Compensation Act also provides these necessary safeguards to guard against the risk of erroneous deprivation. First, the risk of error is minimal because the URO's decision must be based on a medical determination. The Supreme Court has characterized medical reports as "routine, standard and unbiased." *Richardson v. Perales,* 402 U.S. 389, 407 (1971). The Court also recognized the "reliability and probative worth of written medical reports, "emphasizing that while there may be "professional disagreement with the medical conclusions" the "specter of questionable credibility and veracity is not present." *Id.*

Second, as only the injured employee's treating physician may testify before the URO and the URO may only base its decision on this physician's testimony and records, the risk of an erroneous decision becomes even more minimal. In *Mathews*, the disability claimants were not even afforded the benefit of their own medical provider's testimony, as the government could seek its own independent medical examination and decide to terminate benefits on the basis of that physician's report. *Id.* at 337-38. With these guidelines in place, the potential value of an evidentiary hearing is slight.

The decision in *Bakealary* does not require a different conclusion. In *Baksalary*, plaintiffs challenged the constitutionality of the former section 413 of the Workers' Compensation Act, which permitted an automatic supersedeas of *all* benefits. *Baksalary*, 579 F. Supp. at 220. The supersedeas took effect when the employer or insurer filed a petition that alleged either that (1) the employee returned to work at the same or greater rate

of pay or (2) the employee had completely recovered. *Id.* at 221. To be entitled to a supersedeas on the second ground, the petition had to be accompanied by an affidavit of a physician based on an examination made within fifteen days of the filing of the petition. *Id.*

The court in *Baksalary* concluded that the procedure violated due process because the employee was not given prior notice of the suspension nor an opportunity to respond to the doctor's affidavit. *Id.* at 232-33. The court in the concurring opinion also found that the procedure was flawed because of the notice defect and the insufficient guarantee of decisionmaker impartiality. *Id.* at 236-237. These flaws are not present under the current Workers' Compensation Act.

First, the utilization review procedure is much narrower and incorporates more procedural protection than the old automatic supersedeas provision. Under the current system, only payments for specified medical treatment are subject to utilization review and the accompanying suspension of payment as opposed to all benefits-wage replacement as well as medical.

Additionally, the utilization review itself is extremely focused. First, a person licensed in the same profession and having the same or similar specialty as the medical provider must conduct the review. 34 Pa. Code §127.466. Additionally, the reviewer may only apply generally accepted treatment protocols to the case. 34 Pa. Code §127.647.

Based on the application of these protocols, the reviewer must then decide whether the particular treatment is reasonable and necessary for only the medical condition at issue. 34 Pa. Code §127.470. Reviewers must assume that the condition being

treated is related to a work injury. *Id.* They must also refrain from deciding whether an employee is still disabled, whether the employee has obtained maximum medical improvement or whether the fees charged are reasonable. *Id.*

Second, as discussed above, the URO reviewer is only permitted to consider the treating provider's records and testimony in making a decision, thereby ensuring more decisionmaker impartiality. In contrast, the employers or insurers submitted affidavits from physicians of their own choosing under the old provisions.

Third, the current Act provides the plaintiffs with adequate notice regarding the suspension of benefits through the conclusion of the review process. Under the Act, the Bureau is required to serve the employer's or insurer's Request for Review of specific treatment on all parties. 34 Pa. Code §§127.451, 127.452. While this request does not specifically mention that the employee's benefits will be suspended, it does put the employee on notice of the upcoming proceedings.

In actuality, the Bureau may be unable to notify the employee that his or her benefits will be suspended. The statute does not require that the employer or insurer suspend the payment of the employees medical bills following a Request for Review; it merely authorizes it. *See* 34 Pa. Code §127.208 ("[t]he insurer's right to suspend payment. . . .") As the suspension is at the employer's or insurer's discretion, the Bureau provides the employee with the information it has available.

Other jurisdictions have found that provisions which provide employees with this minimal notice are sufficient. In *Cryder v. Oxendine,* 24 F.3d at 178, the court upheld a provision in which

the employer or insurer must notify the employee of termination only ten days in advance.[5] Similarly, in *Sauceda* v. *Department of Labor & Indus.*, 917 F.2d 1216, 1217 (9th Cir. 1990), the court concluded that the Department of Labor only had to provide a claimant with notice indicating its decision and its reasons for the decision and inform the claimant of his right to request reconsideration.[6]

Finally, before the denial of benefits is final, the claimant is entitled to receive a full evidentiary hearing through the *de novo* hearing required upon filing of a Petition for Review.

c. Governmental Interest

The governmental and societal interest present in this case is ensuring that medical benefits are paid only to the employees who are actually disabled. Plaintiffs argue that this requires a consideration of fiscal and administrative burdens and thus cannot be decided on a motion of dismiss.

5. In *Cryder* 24 F.3d at 176-77, the plaintiff contended that the Georgia Workers' Compensation Act violated the Due Process Clause because the ten-day notice of impending termination and its post-termination hearing procedures were constitutionally insufficient to satisfy the requirements of due process. Under the rule in question, the employer or insurer could terminate an employee's benefits without a prior evidentiary hearing in instances where the employee had returned to work without a reduction in compensation or where the employee's authorized treating physician released the employee to normal work duty. *Id.* at 177.

6. In *Sauceda*, the plaintiffs argued that a procedure under which the Department of Labor could suspend employment disability benefits if the claimant refused to submit to medical exams and to participate in vocational programs violated due process. *Sauceda*, 917 F.2d at 1217.

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It is correct that the present record before us does not reflect the precise high costs of worker's compensation with respect to medical treatment and review and just exactly how this legislation will influence those matters in the future. Nevertheless, it is clear that this legislation was enacted in response to high costs of medical treatment, the corresponding high cost of insurance and the need to somehow bring these costs under control.

In *Mathews*, the Court did not rely on the parties' estimates of the additional financial costs but instead held that "[n]o one can predict the extent of the increase, but the fact that full benefits would continue until after such hearings would assure the exhaustion in most cases of this attractive option." *Mathews*, 424 U.S. at 347. Additionally, the Court determined that financial cost alone was not a controlling weight but that the Government's interest in "conserving scarce fiscal and administrative resources is a factor that must be weighed." *Id.* at 348. These same concerns are present in this case as well.[7]

3. **State Action**

In a memorandum filed on January 24, 1996, the Court dismissed the private insurers from the current action after concluding that they were not state actors. The Commonwealth Officials now argue that the privately insured plaintiffs have no claim against them for the withholding of their medical benefits as that deprivation was carried out by private actors. In light of the Court's decision that the Workers' Compensation Act

7. *Mathews* at 349 also instructs us that "the judicial model of an evidentiary hearing is neither a required, nor even the most effective, method of decision making in all circumstances."

comports with due process, it is unnecessary to address this argument further.

C. *The Reconsideration Costs*

In Count III in the Complaint, the plaintiffs assert that the assessment of a fee upon reconsideration review (no longer applicable under existing law) violates the plaintiffs' right to procedural due process.[8] I conclude that the imposition of this fee did not violate due process.

Before Act 1996-57, if either the employee or the employer or insurer was dissatisfied with the initial URO decision, that party could petition the Bureau for reconsideration within thirty days of receiving the decision.[9] However, unlike in the initial review, the Bureau would bill the losing party for the cost of this reconsideration hearing.

The Supreme Court has recognized that the imposition of filing fees can violate the Fourteenth Amendment. *See Boddie v. Connecticut,* 401 U.S. 371 (1971) (mandatory filing fees in divorce cases violate due process since they effectively denied the indigent

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8. In Count IV of the Complaint, the Plaintiffs allege that the assessment of a fee upon reconsideration review violates their right to substantive due process. Neither party addresses this issue and no basis for it appears in the complaint.

9. As stated earlier, Act 1996-57 eliminates the reconsideration step. Act 1996-57, §4, *amending*, Act of June 2, 1915 (P.L. 376, No. 338), §306(f.l)(6). After the URO issues its initial decision, a dissatisfied party need not seek reconsideration through another URO. *Id.* Instead, the party may petition for review of the decision through a *de novo* hearing before a Workers' Compensation Judge. *Id.*

parties the right to be heard); *Little v. Streater,* 452 U.S. 1 (1981) (imposition of costs of blood tests on an indigent party contesting a paternity suit violates due process).

However, the Supreme Court has upheld financial barriers in cases where it deemed that the plaintiffs had no fundamental right at stake. *See United States v. Kras,* 409 U.S. 434 (1973)(payment of filing fees as condition precedent to obtaining discharge in bankruptcy does not violate due process); *Ortwein v. Schwab,* 440 U.S. 656 (1973) (appellate filing fee as applied to indigents seeking to appeal an adverse welfare is not violative of due process).

In this case, the interest at issue is plaintiffs' desire for uninterrupted receipt of their workers' compensation medical benefits. This interest is more akin to the plaintiffs' interests in *Kras* and *Ortwein.* While these interests are important, they simply do not command the same deference as the other rights which the Supreme Court has deemed to be fundamental. *See Bullock v. Carter,* 405 U.S. 134 (1972) (right to vote); *Williams v. Rhodes,* 393 U.S. 23 (1968) (freedom of association); *Shapiro v. Thompson,* 394 U.S. 618 (1969) (right to travel); *Skinner v. Oklahoma ex rel. Williamson,* 316 U.S. 53S (1942) (right to procreate).

However, as the plaintiffs correctly assert, both *Boddie* and its progeny do not turn exclusively on the nature of the interest that the plaintiff sought to vindicate. *See Lecates v. Justice of the Peace Court No. 4,* 637 F.2d 898, 908 (3d Cir. 1980). The Supreme Court has also stressed the existence of alternatives to the judicial remedies which are not conditioned on the payment of fees. *See Kras,* 410 U.S. at 446.

In *Ortwein v. Schwab,* the plaintiffs argued that an Oregon appellate filing fee, which indigents seeking to appeal an adverse

welfare decision had to pay, violated the due process clause of the Fourteenth Amendment. 410 U.S. 656, 658 (1973). The Supreme Court first determined that the indigents had hearings and that those hearings provided "a procedure, not conditioned on payment of any fee, through which [the indigents] have been able to seek redress." *Ortwein*, 410 U.S. at 659-60. The Court then held that "[t]his Court has longed recognized that even in criminal cases, due process does not require a State to provide an appellate system." *Id.* at 660.

Likewise, these plaintiffs have an alternative to the judicial remedies not conditioned on the payment of fees as the expenses for the initial URO hearing are borne by the employer or insurer. *See* 77 P.S. §591(6)(iii) (Purdon's Supp. 1996). As is also required, this hearing meets the minimal requirements of due process. *See Ortwein*, 410 U.S. at 660 n.4. (evidentiary hearings must meet the minimal requirements of due process).

Plaintiffs however argue that *Ortwein* and *Kras* are still inapposite to this case because those cases concern challenges by persons seeking to initiate a judicial process. In support of their argument, the plaintiffs cite *Lecates v. Justice of the Peace Court No. 4*, 637 F.2d at 908 for the proposition that these factors (the nature of the interest involved and the alternatives to judicial remedies) are irrelevant when a defendant is brought into court against his or her will.

In *Lecates*, the plaintiff argued that a nonwaivable bond requirement operated to deny indigents due process of the law. 637 F.2d at 900. Under the two-tier trial court system in Delaware, a plaintiff who was unsuccessful before the justice of the peace court (the first tier) was entitled to a trial *de novo* in Superior Court (the second tier). *Id.* The losing defendant in the

justice of peace court, however, had to first post a surety bond in order to obtain such a trial. *Id.* The value of the surety bond had to be equal to the amount of judgment plus costs, but could be higher at the discretion of the magistrate. *Id.* at 901.

In determining that this surety bond requirement violated due process, the Third Circuit Court of Appeals first determined that "persons forced to settle their claims of right and duty through the judicial process must be given a meaningful opportunity to be heard." *Lecates*, 637 F.2d at 909 (citing *Brodie,* 401 U.S. at 377). Therefore, as the court held that the right to receive a trial *de novo* in Superior Court was a constitutional requirement, the court concluded that "Delaware may not, consonant with due process, make a defendant's opportunity to enjoy the right dependant on the amount of money he has." *Id.*

In contrast, the plaintiffs' right to a reconsideration hearing is not dependant on the amount of money he or she has. As the Bureau advances the costs of reconsideration, an employee, unlike the plaintiff in *Lecates*, is not denied access to the appellate system, or in this case, reconsideration by another URO. 34 Pa. Code §127.514(9)(a).

Additionally, any party dissatisfied with the decision on reconsideration may then seek further review by filing another petition with the Bureau. 77 P.S. §531(6)(iv) (Purdon's Supp. 1995). The Bureau then assigns the petition to a Workers' Compensation Judge for a *de novo* hearing. Not only is there no cost for this hearing, but the employee may recover the cost of the litigation at this level if he or she prevails. 77 P.S. §996 (Purdons Supp. 1996). Therefore, even under *Lecates*, the assessment of the fee does not violate due process.

Appendix C

D. *The Regulations*

In Count V of the Complaint, the plaintiffs allege that the lack of regulations governing procedures before Workers' Compensation Judges reviewing URO decisions violates the plaintiffs' rights to procedural due process. Specifically, the plaintiffs argue that the regulations promulgated by the Bureau fail to provide any standard for determining whether a challenged treatment is "reasonable and necessary" and provide no guidance as to how petitions for review are to be litigated before Workers' Compensation Judges. I conclude that the Bureau has promulgated sufficient regulations and provided adequate guidance to the Workers' Compensation Judges.

The establishment of "'written, objective, and ascertainable standards is an elementary and intrinsic part of due process." *Baker-Chaput v. Cammett,* 406 F. Supp. 1134, 1140 (D.N.H. 1976). Without these standards, the underlying purpose of providing due process in the first place — to reduce the risk of error through arbitrary decision making — cannot be met. *Carey v. Ouern,* 588 F.2d 230, 232 (7th Cir. 1978). A system without such standards and which vests unfettered discretion in the decisionmaker violates due process. *White v. Roughton,* 530 F.2d 750, 754 (7th Cir. 1976).

In this case, the regulations at issue provide more than enough guidance to the doctors and other health care providers who conduct the utilization review. Although these regulations do not specifically define the standard of "reasonable and necessary" medical treatment, they provide the reviewer with ample guidance on how to approach this question.

For example, under the regulations, the reviewer must base his or her decision on generally accepted treatment protocols

and appropriate medical literature. 34 Pa. Code §127.472. Additionally, the reviewer is limited in his or her inquiry and may not consider whether the injury is work-related, whether the employee is still disabled, whether the employee has reached maximum medical improvement or whether the provider's fees are reasonable. 34 Pa. Code §127.470.

Not only do these regulations provide the reviewer with guidance, the regulations also serve the equally necessary function of limiting the discretionary power of the reviewer. *See White*, 530 F.2d at 754 (administrator's procedure of allowing staff to determine eligibility for assistance grants based on their own unwritten standards was violative of due process); *Moe v. Brookings County*, 6Sg F.2d 830, 883 (8th Cir. 1981) (system which gives county commissioner complete discretion in determining the availability of assistance violated due process). As the reviewer must abide by the guidelines described above and must furnish the parties with a detailed written opinion, the reviewers authority is appropriately curtailed. *See* 34 Pa. Code §127.472.

Second, the Bureau has also provided the Workers' Compensation Judges with adequate guidance. First, these Judges have the benefit of a *de novo* hearing. As they are adjudicators in this adversarial proceeding, they hear testimony and must make decisions within the framework of the evidence, the statute and the case law. Additionally, the regulations provide that the Judges shall consider the utilization report as evidence but shall not be bound by the report. Act 1996-57, §4, *amending*, Act of June 2, 1915 (P.L. 376, No. 338), §306(f.1)(6)(iv). As these Judges do not have complete discretion, the lack of uniformity in judicial decisions by itself does not violate due process. *See Bishop v. Mazurkiewicz*, 634 F.2d 724, 726 (3d Cir. 1980), *cert. denied*, 452 U.S. 917 (1981).

Appendix C

IV. *CONCLUSION*

For the above reasons, Commonwealth Officials' motion to dismiss the amended complaint is granted.

An order follows.

Appendix C

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

DELORES SCOTT SULLIVAN, *et al.*,

Plaintiffs,

JOHNNY J. BUTLER, *et al.*,

Defendants.

CIVIL ACTION

No. 95-201

ORDER

AND NOW, this 7th day of November, 1996, upon consideration of Defendants' Motion to Dismiss Plaintiffs' Amended Complaint (Docket No. 45), and plaintiffs' response thereto, it is hereby ORDERED that said Motion is GRANTED, and the Amended Complaint is DISMISSED as to defendants Johnny J. Butler, the Secretary of Labor and Industry for the Commonwealth of Pennsylvania, Richard A. Himler, the Director of the Bureau of Workers' Compensation, Linda Kaiser, the Insurance Commissioner, Catherine Baker Knoll, the State Treasurer, and Ralph Chase, the Director of the State Workmen's Insurance Fund, ("Commonwealth Officials").

BY THE COURT:
s/ Ronald L. Buckwalter, J.
RONALD L. BUCKWALTER, J.

APPENDIX D — OPINION OF THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA FILED MARCH 8, 1996

Delores Scott SULLIVAN, et al.,

Plaintiff,

Robert BARNETT, et al.,

Defendants.

NO. 95-201

United States District Court, E.D. Pennsylvania

March 8, 1996

MEMORANDUM

BUCKWALTER, J.

Plaintiffs have filed a Motion for Final Order Under Rule 54(b). The Third Circuit has instructed the court to address two distinct issues.

> First, whether "it is dealing with a 'final judgment' . . . in the sense that it is 'an ultimate disposition of an individual claim entered in the course of multiple claim entered in the course of multiple claims action.' " Curtiss-Wright Corp. v. General Electric Co., 446 U.S. 1, 7, 100 S.Ct. 1460, 1464, 64 L.Ed.2d 1 (1980). If that hurdle is cleared, the district court must exercise its discretion to determine

> that the matter is "ready for appeal . . . tak[ing] into account judicial administrative interests as well as the equities involved." Id. at 8, 100 S.Ct. at 1465.

Sussex Drug Products v. Kansco, Ltd., 920 F.2d 1150, 1153 (3d Cir. 1990).

I believe the order granting defendant insurers' motion to dismiss was final for purposes of Rule 54(b).

> Finality is defined by the requirements of 28 U.S.C. § 1291, which are generally described as ending "the litigation on the merits and leav[ing] nothing for the court to do but execute the judgment."

Sussex, supra p. 1153 (citations omitted)

As to the second question I recognize instantly that piecemeal appeals are disfavored. Quoting from Sussex again, the court made reference to the following:

> The Federal Courts Study Committee Report revealed that the federal appellate case load has increased ten-fold over the past thirty years. "However, people may view other aspects of the federal judiciary, few deny that its appellate courts are in a 'crises of volume' that has transformed them from the institution they were even a generation ago." Report of the Federal Courts Study Committee 109 (1990)
>
> Acknowledging that concern, one respected commentator noted that "courts of appeals, under

> the weight of very heavy dockets, are increasingly resistant to piecemeal appeal." Further, "despite the jurisdictional cast of the decisions, their content is increasingly directed to practical considerations of judicial administration." 6 J. Moore, W. Taggart & J. Wickers, Moore's Federal Practice ¶ 54.33[2], at 54-197 (1990).

Sussex, supra, p. 1156

It has been said that Rule 54(b) is to be used in the "infrequent harsh case", Allis-Chalmers Corp. v. Philadelphia Electric Co., 521 F.2d 360, 363 (1975).

Obviously such an order should not be granted unless the party seeking it can show some compelling reason or reasons which place their case in the "infrequent harsh" category. Plaintiffs' argument in this regard (pp. 5, 6 and 7 of their brief) is not persuasive. Moreover, the state actor issue, upon which defendant insurers' motion to dismiss was based, may have to be revisited by the Court of Appeals with regard to the School District of Philadelphia since the district's status as state actor remains unresolved in the present district court proceedings. I note, also, that essential to plaintiffs' complaint is their claim that the effect of Section 306(f.1)(5) of the Pennsylvania Workers's Compensation Act, as a result of defendants acting pursuant thereto, is to deprive them of property without due process. This court's ruling on that issue will likely be before the Court of Appeals which would then consider the state actor issue as well. This makes much more sense from a judicial administration perspective. The very thing that the Court of Appeals seeks to avoid, i.e., piecemeal litigation, would occur

if I were to grant plaintiffs' motion, and I find no equities involved which clearly support the requested relief.

An order follows.

ORDER

AND NOW, this 8th day of March, 1996, upon consideration of plaintiffs' Motion for Final Order Under Rule 54(b), and the response thereto by the insurance company defendants, it is hereby ORDERED that said motion is DENIED.

APPENDIX E — MEMORANDUM AND ORDER OF THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA ENTERED JANUARY 24, 1996

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

CIVIL ACTION

NO. 95-201

DELORES SCOTT SULLIVAN et al.,

Plaintiff,

ROBERT BARNETT, et al.,

Defendants,

MEMORANDUM

BUCKWALTER, J. JANUARY 24, 1996

I. BACKGROUND

Plaintiffs in this putative civil rights class action claim to be persons who had been receiving medical benefits pursuant to the Pennsylvania Worker's Compensation Law, and who were thereafter deprived of those benefits without prior notice or an opportunity to be heard pursuant to what plaintiffs' counsel characterize as an "automatic-supersedeas" as provided by Section 306 (f.1)(5) of the aforesaid law, as amended, 77 P.S. 531 (5) (Supp. 1994) , which provides in part as follows:

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The employer or insurer shall make payment and providers shall submit bills and records in accordance with the provisions of this section. All payments to providers for treatment provided pursuant to this act shall be made within thirty (30) days of receipt of such bills and records unless the employer or insurer disputes the reasonableness or necessity of the treatment provided pursuant to paragraph (6.) A provider who has submitted the reports and bills required by this section and who disputes the amount or timeliness of the payment from the employer or insurer shall file an application for fee review with the department. Within thirty (30) days of the filing of such an application, the department shall render an administrative decision.

Paragraph 6 provides, in part, as follows:

Except in those cases in which a referee asks for an opinion from peer review under section 420, disputes as to reasonableness or necessity of treatment by a health care provider shall be resolved in accordance with the following provisions:

(i) The reasonableness or necessity of all treatment provided by a health care provider under this act may be subject to prospective, concurrent or retrospective utilization review at the request of an employe, employer or insurer. The department shall authorize utilization review organizations to perform utilization review under this act. Organizations not authorized by the department may not engage in such utilization review.

(ii) The utilization review organization shall issue a written report of its findings and conclusions within thirty (30) days of a request. If the provider, employer, employe or insurer disagrees with the finding of the utilization review organization, a request for reconsideration must be filed no later than thirty (30) days after receipt of the utilization review report. The request for reconsideration must be in writing.

(iii) The employer or the insurer shall pay the cost of the initial utilization review. The party which does not prevail on reconsideration of an initial review shall bear the costs of such reconsideration.

(iv) If the provider, employer, employe or insurer disagrees with the finding of the utilization review organization on reconsideration, a petition for review by the department must be filed within thirty (30) days after receipt of the reconsideration report. The department shall assign the petition to a referee for a hearing.

The "automatic supersedeas" to which plaintiffs refer is implemented by regulations which, as of November 11, 1995, provide in part as follows. All regulations hereafter set forth come from exhibits supplied to the court by plaintiffs' counsel.

§127.208. Time for payment of medical bills.

(a) Payments for treatment rendered under the act shall be made within 30 days of receipt of the bill and report submitted by the provider.

(e) The 30-day period in which payment shall be made to the provider may be tolled only if review of the reasonableness or necessity of the treatment is requested during the 30-day period under the UR provisions of Subchapter C (relating to medical treatment review). The insurer's right to suspend payment shall continue throughout both the initial review and the reconsideration review of the UR process. The insurer's right to suspend payment shall further continue beyond the UR process to a proceeding before a Workers' Compensation judge, unless there is a UR determination made at reconsideration that the treatment is reasonable or necessary.

(f) If a URO determines that medical treatment is reasonable or necessary, at reconsideration, the insurer shall pay for the treatment. Filing a petition for review before a Workers' Compensation judge, does not further suspend the obligation to pay for the treatment once there has been a determination at reconsideration that the treatment is reasonable or necessary. If it is finally determined that the treatment was not reasonable or necessary, and the insurer paid for the treatment in accordance with this chapter, the insurer may seek reimbursement from the Supersedeas Fund under section 443 (a) of the act (77 P.S. §999).

The Utilization Review (UR) provisions of Subchapter C relating to medical treatment review provide in part as follows:

§ 127.401. Purpose — review of medical treatment.

(a) Section 306 (f.1) (6) of the Act provides a utilization review (UR) process, intended as an impartial review of the reasonableness or necessity of medical treatment rendered to, or proposed for, work-related injuries and illnesses.

(b) UR is a three-step process, that may be requested by multiple parties:

1. The first-step is the initial request that may be made by, or on behalf of, the employer, insurer or employe.

2. The second-step is the request for reconsideration that may be made by, or on behalf of the employer, insurer, employe or health care provider.

3. The third-step in the petition for review of utilization review, that may be filed by, or on behalf of, the employer, insurer, employe or health care provider.

(c) Review of medical treatment shall be conducted only by those organizations authorized an utilization review organizations (UROs) by the Secretary, pursuant to the process set forth in §127.650 through §127.670.

§127.403. Assignment of cases to UROs.

The Bureau will randomly assign requests for UR to authorized UROs. An insurer's obligation to pay medical bills within 30 days of receipt shall be tolled only when a proper request for UR has been filed with the Bureau in accordance with the provisions of this Subchapter.

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§127.451. Initial requests for utilization review — who may file.

Initial requests for UR may be filed by an employe, employer or insurer. Health care providers may not file initial requests for UR.

§127.452. Initial requests For utilization review — filing and service.

(a) A party seeking UR of treatment rendered under the Act shall file the original and copies of a form prescribed by the Bureau as an initial request for utilization review. All information required by the form must be provided. Where available, the filing party shall attach authorizations to release medical records of the providers listed on the request.

(b) The initial request for UR shall be served on all parties and their counsel (if known) and the proof of service on the form shall be executed. If the proof of service is not executed, the request for UR will be returned by the Bureau.

(c) Initial requests for UR shall be sent to the Bureau at the address listed on the form.

§177.453. Initial retreats for utilization review — assignment by the Bureau.

(a) The Bureau will randomly assign a properly filed request for UR to a certified URO (Utilization Review Organization).

(b) The Bureau will send a notice of assignment of the request for UR to the URO; the employe; the employer or insurer; the health care provider under review, and the attorneys for the parties, if known.

§127.476. Duties of UROs— form and service of determinations.

(a) Each determination rendered by a URO on the merits shall include a form prescribed by the Bureau as a medical treatment review determination face sheet and the reviewer's report. The face sheet shall be signed by an authorized representative of the URO.

(b) When a determination is rendered against the provider under review on the basis that no records were supplied by the provider, the determination shall consist only of the face sheet. However, in such cases, the face sheet shall clearly indicate that the basis for the decision is the failure of the provider under review to supply records to the URO.

(c) The URO's determination, consisting of both the face sheet and the reviewer's report, shall be served on the employe, the insurer or employer, the provider under review, the attorneys for the parties (if known), and the Bureau.

(d) The URO shall also serve a copy of a form prescribed by the Bureau for filing requests for reconsideration on all parties and their attorneys (if known).

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§127.501. Reconsideration of initial utilization review determination — who may file.

If the provider under review, the employe, the employer or the insurer disagrees with the initial UR determination rendered, a request for reconsideration may be filed with the Bureau.

§127.502. Reconsideration — time for filing.

Within 30 days of receipt of the initial UR determination the party requesting reconsideration shall file with the Bureau the original and 8 copies of the form prescribed by the Bureau as a request for reconsideration. Requests for reconsideration shall be sent to the Bureau at the address listed on the form.

§127.503. Reconsideration — service.

(a) The request for reconsideration shall be served on all parties and their attorneys (if known). The proof of service on the request for reconsideration shall be executed.

§127.509. Assignment of reconsideration to reviewer by URO.

(a) The URO shall forward the medical records used for the initial UR, together with any additional records supplied by the provider under review, to a reviewer other than the reviewer who performed the initial UR. The reviewer performing the reconsideration shall be licensed by the Commonwealth of Pennsylvania in the same profession and Board-certified in the specialty or sub-specialty of the provider under review. In the

case of physicians, Board-certification shall be by an accredited specialty board.

§127.512. Reconsideration — Form end service of determination.

(a) The determination by a URO on a reconsideration shall be in the form prescribed by §127.476 (relating to form and services of determinations).

(b) The determination by a URO on a reconsideration shall be served in accordance with the requirements prescribed by §127.476 (relating to form and service of determinations).

§127.551. Petition for Review by Bureau of utilization review determination.

If the provider under review, the employe, the employer or the insurer disagrees with the determination rendered on reconsideration, a request for review by the Bureau may be filed on a form prescribed by the Bureau as a petition for review of a utilization review determination.

§127.556. Petition for Review by Bureau — *de novo* hearings

The hearing before the Workers' Compensation Judge shall be a *de novo* proceeding. The Workers' Compensation Judge shall not be bound by any prior determinations made during the UR process.

Based substantially upon the above referenced law and regulations (and arguably some not set forth above); the deposition testimony of David R. Weyl, Chief of the Medical Cost Containment Division, Bureau of Workers' Compensation, Department of Labor and Industry, Commonwealth of Pennsylvania; Laura S. Keller, manager of the medical treatment, review section for the Bureau of Workers' Compensation; Carl M. Lorine, a current Workers' Compensation Judge; and Cheryl M. Lapotin, Workers' Compensation claims manager for the School District of Philadelphia, plaintiffs contend that both the defendant private insurers and the defendant school district, acting through its third party administrator, are acting jointly with the state when they "unilaterally terminate medical benefits pursuant to the utilization review." (Pls.' Br. at 18).

II. DISCUSSION

The question presented in connection with defendants' motions to dismiss and plaintiffs' motion for partial summary judgment is: Are the private insurer defendants and school district defendants state actors?[1]

In *Mark v. Borough of Hatboro*, 51 F.3d 1137 (3d Cir. 1995), the court reiterated the Supreme Court's pronouncement that in cases under §1983, such as this case, "under color" of

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1. Since defendants' motions contested factual allegations in the plaintiffs' complaint and appeared to rely upon facts outside the complaint, plaintiffs moved the court to permit them to take a limited amount of discovery prior to answering the motions and to convert the motions to dismiss to motions for summary judgment. The court permitted plaintiffs a period of forty-five (45) days to conduct discovery on the issue of state action. The discovery period was subsequently extended to July 14, 1995. Oral argument on the motions was held on December 13, 1995.

law is treated as the same thing as the "state action" requirement of the Fourteenth Amendment, *Mark*, 51 F.3d at 1141 *citing United States v. Price*, 383 U.S. 787, 794 n.7, 86 S.Ct. 1152, 1157 n.7, 16 L.Ed.2d 267 (1966) (quoted in *Lugar v. Edmonson Oil Co.*, 457 U.S. 922, 928, 102 S.Ct. 2744, 2749, 73 L.Ed.2d 482 (1982) . . . and *Rendell-Baker v. Kohn*, 457 U.S. 830, 838, 102 S.Ct. 2764, 2769-70, 73 L.Ed.2d 418 (1982). The court went on to recite the three discrete tests to determine whether there has been state action. They are:

> (1) Does the private entity exercise powers that are traditionally the exclusive prerogative of the state.
>
> (2) Has the private entity acted with the help of or in concert with state officials.
>
> (3) Has the state so far insinuated itself into a position of interdependence with the private entity that it must be recognized as a joint participant in the challenged activity (sometimes referred to as the symbiotic relationship test). *Mark*, 51 F.3d at 1142-1143 (citations omitted).

A. Private Insurer Defendants.

Plaintiffs contend that the relationship between the state and the private insurer defendants in utilization review ("UR") is "so interstitial as to render the defendants state actors for purposes of the Fourteenth Amendment when they involve utilization review and cease, or supersede, medical benefits to claimants on that basis." (Pls.' Br. at 2-3).

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The facts upon which plaintiffs seem to rely to justify the above conclusion are the following:

1. The historical roots of the Workers' Compensation Act, and the system it created.

It is mandatory under the act that employers provide workers compensation for their employees. In exchange, the employee is required to relinquish his right to sue his employer in tort. While the employee has the right to have insurance coverage at no cost, he has no right to opt out of the workers' compensation system in favor of his own private insurance coverage or none at all.

2. The operation of the Workers' Compensation System.

The Bureau of Workers' Compensation of the Pennsylvania Department of Labor and Industry (hereafter "Bureau"), is the administrator of the Workers' Compensation Act and has adopted its own rules and regulations by which it actively enforces the Act and ensures compliance with it. The Bureau has adopted forms to be used for various reporting requirements included in the Act.

3. **Bureau's specific role in the utilization review process under 77 P.S. §531(5) and regulations.**

"The Bureau serves the dual function of gate keeper and traffic cop" (Pls.' Br. at 12) in that access to the utilization review system can only be gained by filing the Bureau's form. Once that form has been completed properly and submitted in timely

fashion, an insurer may stop payments for medical treatment. In order for its obligation to pay medical bills to be tolled, the insurer must submit a proper request for UR within 30 days of receipt of the medical bills. The propriety of the request as initially determined by the Bureau is based solely upon formal issues regarding the Bureau's form and involves no consideration of the merits of the request. If the formal requirements of the form are met, the Bureau then assigns the case to a Utilization Review Organization ("URO"). When the URO completes its report, it must file a copy of it with the Bureau. Any party — that is, employer, insurer, provider or employe — may file for reconsideration, after which filing the Bureau assigns the case to a URO for review. The URO performing this reconsideration review must file a copy of its report with the Bureau.

Any party aggrieved by the reconsideration review may file a petition for review with the Bureau, which assigns it to a Workers' Compensation judge, who considers the matter *de novo*. While the employs cannot participate in either the initial UR or the reconsideration review, he can participate fully in the *de novo* proceeding before the Workers' Compensation judge.

Essentially, plaintiffs argue that insurer defendants are state actors when they request a UR because (1) the state has created the workers' compensation system which is administered by the Bureau; (2) the insurer can only access the system by the use of official forms prepared by the state through the Bureau; and (3) the insurers will not be permitted to toll payments of medical benefits unless the forms they file comply with the Bureau's procedural provisions and "substantive criteria" permitted by statute or regulations.[2]

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2. For a discussion of whether the criteria examined by the Bureau are in fact "substantive" or merely procedural, see this opinion, *infra* at 22, 23.

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The insurer defendants argue that contrary to being state actors, they are private entities who independently make a decision whether to request utilization review. Once they decide to seek UR, the stature "is self-executing, meaning that the obligation to make payment is determined solely by whether or not there has been a request by the employer or insurer for utilization review." (Defs.' Mem at 2). Because the decision to seek UR it made independently, insurer defendants argue, "the determination of whether or not there is a payment obligation does not depend on the actions of any public agency or official." *Id.*

Before embarking on an evaluation of the specific facts of the present case, I feel it is important to note the basic constitutional principles relevant to the discussion of this case. An the Supreme Court stated in *Edmonson v. Leesville Concrete Co. Inc.* , 500 U.S. 614, 111 S.Ct. 2077, 114 L.Ed.2d 660 (1991):

> One great object of the Constitution is to permit citizens to structure their private relations as they choose subject only to the constraints of statutory or decisional law.
>
> To implement these principles, courts must consider from time to time where the governmental sphere ends and the private sphere begins. Although the conduct of private parties lies beyond the Constitution's scope in most instances, governmental authority may dominate an activity to such an extent that its participants must be deemed to act with the authority of the government and, as a result, be subject to constitutional constraints. This is the jurisprudence of state action, which explores the "essential dichotomy" between the private sphere and the public

> sphere, with all its attendant constitutional obligations.

Edmonson, 500 U.S. at 619-620, Ill S.Ct. 2083 (citations omitted). It is with these considerations in mind that I proceed with the following analysis.

In *Lugar v. Edmondson Oil Co.,* 457 U.S. 922, 102 S.Ct. 2744, 73 L.Ed.2d 482 (1992), the Supreme Court set forth the test now relied upon in evaluating state action questions under Section 1983. That framework is utilized and effectively explained by the court in the more recent case of *Edmonson v. Leesville Concrete.* Since this analytical framework appears to have been taken up by the Third Circuit, *see, e.g., Mark,* 51 F.3d 1137, I have attempted to follow what will call the *Edmonson/Lugar* test in answering the question presented here.

The *Edmonson/Lugar* test consists of two basic questions;

> (1) Has the claimed constitutional deprivation resulted from the exercise of a right or privilege having its source in state authority; and
>
> (2) Can the private entity charged with the deprivation be described in all fairness as a state actor.

Edmonson, 500 O.S. at 620, 111 S.Ct. at 2083 and 2083.

In *Lugar,* the first of the two basic questions was answered the same way as the question should be answered in this case; namely, the procedural scheme created by the statute obviously

is the product of state government and the statute has its source in state authority. However, both *Lugar* and *Edmonson* make it clear that this in only the beginning of the inquiry.

The second question, involves an examination of the following fact-based elements:

> (1) The extent to which the private entity relies on governmental assistance and benefits;
>
> (2) Whether the private entity is performing a traditional government function; and
>
> (3) Whether the injury caused is aggravated in a unique way by the incidence of governmental authority.

Edmonson, 500 U.S. at 621-622, 111 S.Ct. at 2083 *citing Lugar,* 457 U.S. at 942, 102 S.Ct. at 2754-2756.

In connection with the first element of the second question, the Court in *Edmonson* instructed that private use of state-sanctioned private remedies alone does not rise to state action unless private parties make extensive use of state procedures with the "overt, significant assistance of state officials." *Edmonson,* 500 U.S. at 622, 111 S.Ct. at 2083, 2084 (*quoting Tulsa Professional Collection Services, Inc. v. Pope,* 485 U.S. 478, 485, 108 S.Ct. 1340, 1345, 99 L.Ed.2d 565 (1988) (additional citations omitted). *Lugar* and *Edmonson* provide examples of overt, significant assistance of state officials. *See also Sniadach v. Family Finance Corp. of Bay View,* 395 U.S. 337, 89 S.Ct. 1820, 23 L.Ed.2d 349 (1969).

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In *Lugar,* the prejudgment attachment procedure required only that the plaintiff allege in an *ex parte* petition that defendant was disposing of his property (or might dispose of it) to defeat his creditors. Upon receiving this petition, the clerk in the state court would issue a writ of attachment which was then executed by the Sheriff. Although the property was left in defendant's possession, the execution of the writ of attachment by the Sheriff effectively sequestered it. Thus, in *Lugar,* and earlier in *Sniadach,* the court held that a private party's joint participation with state officials in the seizure of disputed property is sufficient to characterize the private party, in all fairness, a "state actor" for purposes of the Fourteenth Amendment.

However, *Lugar,* upon which plaintiffs rely substantially, seems to be limited to the context of prejudgment attachment. *Lugar* 457 U.S. at 939, n.21, 102 S.Ct. 2755, n.21, as noted by the Court in *Lugar,* the question of whether a private entity in all fairness can be described as a state actor is a "fact bound" one, and so the ruling in one case may not necessarily be extrapolated to another case's fact pattern.

The *Edmonson* case decided that a private litigant in a civil case who uses peremptory challenges to exclude jurors on account of race, has to in all fairness be deemed a government actor.

In summarizing the extent to which a private party relied on government assistance, the Court in *Edmonson* carefully analyzed the facts of the case and the functions of the private and state participants in the jury selection process, stating:

> As we have outlined here, a private party could not exercise its peremptory challenges absent the overt,

> significant assistance of the court. The government summons jurors, constrains their freedom of movement, and subjects them to public scrutiny and examination. The party who exercises a challenge invokes the formal authority of the court, which must discharge the prospective juror, thus effecting the "final and practical denial" of the excluded individual's opportunity to serve on the petit jury. *Virginia v. Rives,* 100 U.S. 313, 322, 25 L.Ed. 667 (1880). Without the direct and indispensable participation of the judge, who beyond all question is a state actor, the peremptory challenge system would serve no purpose. By enforcing a discriminatory peremptory challenge, the court "has not only made itself a party to the [biased act], but has elected to place its power, property and prestige behind the [alleged] discrimination." *Burton v. Wilmington Parking Authority,* 365 U.S. at 725, 81 S.Ct. at 862. In so doing, the government has "create[d] the legal framework governing the [challenged] conduct," *National Collegiate Athletic Assn.,* 488 U.S. at 192, 109 S.Ct. at 462, and in a significant way has involved itself with invidious discrimination.

Edmonson, 500 U.S. at 624, 111 S.Ct. 2084-2085. In addition, *Edmonson* then considered the other two factors in deciding whether a private entity in all fairness can be described as a state actor, and concluded that the action in question involved a traditional government function (selection of a jury) and was aggravated in a unique way because the government permits the discrimination to occur within the courthouse.

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The above cases involving joint participation with state officials in the seizure of property and the private litigants' use of peremptory challenges to exclude jurors on account of race, are examples of governmental assistance and benefits which have been sufficiently extensive to support an ultimate finding of "state actor" according to the test outlined in *Edmonson.*

Into the above category also must fall a case arising from this district which cannot be overlooked because it deals with a challenge to a past method by which an employer or insurer obligated to pay benefits under the Pennsylvania Workers' Compensation Act could cease paying those benefits: *Baksalary v. Smith,* 519 F.Supp. 218 (1984).

The section of the Act involved in *Baksalary* provided, in part:

> The filing of a petition to terminate or modify a notice of compensation payable or a compensation agreement or award as provided in this section shall operate as a supersedeas, and shall suspend the payment of compensation fixed in the agreement or by the award, in whole or to such extent as the facts alleged in the petition would, if proved, require only when such petition alleges that the employe has returned to work at his prior or increased earnings or where the petition alleges that the employe has fully recovered and is accompanied by an affidavit of a physician on a form prescribed by the [Bureau of Worker's Compensation] to that effect which is based upon an examination made within fifteen days of the filing of the petition.

77 P.S. §774 (1992).

The rationale of the *Baksalary* court with regard to the state actor issue of private insurers can best be summed up by the following:

> The Supreme Court has "consistently held that a private party's joint participation with state officials in the seizure of disputed property is sufficient to characterize that party as a 'state actor' for purposes of the Fourteenth Amendment." *Lugar* 457 U.S. at 941 , 102 S.Ct. at 2756. "[I]n this context 'joint participation' [does not require] something more than invoking the aid of state officials to take advantage of state created attachment procedures." 457 U.S. at 942, 102 S.Ct. at 2756.
>
> Section 413's automatic supersedeas procedure requires a filing with the Bureau of Worker's Compensation. This filing is sufficient to constitute "joint participation" and to subject private invocation of the automatic supersedeas to the due process clause.

Baksalary, 579 F.Supp. 231, 232.

Cases finding no state action since *Baksalary* are numerous and, of course, "fact driven." *Mark,* 51 F.3d 1137, although it found state action, is significant to my decision in this case for at least two reasons. First, the court explained that in *Edmonson,* the Supreme Court clarified the *Lugar* joint participation test in part by describing in more detail the second prong of that test. This more detailed explanation in *Edmonson* came well after

the *Baksalary* decision. Second, *Mark* involved the question as to whether the Borough and Enterprise Fire Company, a volunteer fire company, could be liable under §1983 for damages resulting from arson committed by a member of that company. The facts which supported state action show how governmental authority can so dominate an activity that its participants must be considered state actors.

The *Mark* court initially concluded in analyzing the second factor of the *Edmonson/Lugar* criteria that the fire company did provide services which are a traditional government function. It also undertook an analysis as to the extent to which the fire company relied upon government assistance and benefits (the first *Edmonson/Lugar* factor, 500 U.S. at 620, 111 S.Ct. at 2082). It noted that numerous legislative enactments interweave the functioning of government and the fire company. Also in this particular case, the fire company had an agreement with the Borough whereby the Borough agreed to provide sufficient funds for its operation and capital expenditures by imposition of a fire tax. The fire company was designated as "the duly appointed fire company to service the Borough of Hatboro." The fire chief was required to attend meetings of the Borough council. *Mark*, 51 Fed at 1147.

While not using the terminology of the third *Edmonson/Lugar* factor, the court in *Mark* did explain that the alleged wrongful act (the method of electing firefighters) was directly related to the state created duty to provide fire protection in the first place. By way of contrast, the facts in a series of cases not finding state action follow.

In *Jordan v. Fox, Rothschild, O' Brien & Frankel*, 20 F.3d 1250 (3d Cir. 1994), the court found that the entry of judgment

by confession did not involve state action. The court agreed with the district court that "a state procedure permitting private parties to file a complaint and confess judgment essentially involves acquiescence by the state, not compulsion. In such circumstances, private conduct is not attributable to the state." *Jordan*, 20 F.3d at 1266. Similarly, defendant insurers feel that what they do in making an independent decision to withhold payment of medical benefits and thereafter file the appropriate form "essentially involves acquiescence by the state, not compulsion."

I should note that in *Jordan*, which followed *Lugar*, the court found that when a judgment creditor uses Pennsylvania procedure for executing on a conferred judgment, he becomes a state actor. It seems clear in the line of cases dealing with confessed judgments and procedures for collection that a distinction is made between what is or is not a significant contribution by the state to the Constitutional deprivation; that is, has the state by statute authorized its own officers to invoke the force of law in aid of a private person's request. *See also Tulsa Professional Collection Services, Inc. v. Pope* 485 U.S. 478, 108 S.Ct. 1340, 99 L.Ed.2d 565 (1988) (in which state action found because executrix not authorized to act until appointed by court under Oklahoma probate code).

Three cases since *Baksalary* seem to suggest by their ultimate conclusion that state statutes similar to the one in this case do not authorize its officers to invoke the force of law in aid of a private person's request: *Barnes v. Lehman*, 861 F.2d 1383 (5th Cir. 1988); *Grenz v. EBI/Orion Group, Inc.*, 968 F.2d 1220 (9th Cir. 1992); and *Fleming v. Workers' Compensation Commission*, 878 F.Supp. 852 (E.D. Va. 1995).

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In *Barnes*, in which a worker's benefits could be stopped, by statute, based on a doctor's medical opinion, the plaintiff argued that the insurers invoked the aid of state officials when filing the forms incident to ceasing payment. But the *Barnes* court held: "Regulations that dictate procedures, forms or even penalties without dictating the challenged action do not convert private action into state action. The decision to adopt Dr. Lehman's opinion as final and to cease Barnes' benefits was a decision initiated by the insurer and not the state." *Barnes*, 861 F.2d at 1387.

The *Barnes* court, in commenting on *Lugar,* found that prejudgment attachment cannot be equated to a summary termination of compensation benefits without an adjudication or administrative hearing. The court went on to cite *Flagg Bros. Inc. v. Brooks*, 436 U.S. 149, 98 S.Ct. 1729, 56 L.Ed.2d 185 (1978) for the proposition that the "total absence of overt official involvement plainly distinguishes" the actions of private entities pursuant to a self help provision of the New York Commercial Code from actions of creditors acting jointly with state officers pursuant to prejudgment attachment procedures. *Barnes,* 861 F.2d at 1387 (*citing Flagg Bros.*, 436 U.S. at 157, 98 S.Ct. at 1733).

In *Grenz,* the plaintiff argued that the state of Montana and the insurers are joint participants in the workers' compensation scheme because the state mandates workers' compensation, certifies and regulates workers' compensation insurance companies, and provides workers' compensation directly to a significant number of workers. The state itself, however, apparently has nothing to do with the panel of physicians who examine plaintiff pursuant to Montana law to determine whether he in still eligible for benefits or what the insurer does thereafter

based on its findings. The Montana law does require the plaintiff to submit to the examination by the panel. If the insurer does alter the benefits, the worker may challenge the change in the Montana Workers' Compensation Court. The analysis in *Grenz* is brief. Citing *Edmonson,* the court concludes that the insurers were not state actors, even though benefits are altered or terminated prior to a hearing.

Fleming involved a Virginia statute. In that state an employee's right to compensation ceases upon her unjustified refusal to accept suitable employment. To implement this statute, the commission rules permit an insurer to suspend or modify compensation pending acceptance or rejection of an employer's application filed to allege such unjustified refusal. The court stated "USF&G is authorized, but not required, to suspend benefits. And, while the Commonwealth authorizes the challenged action, it does not dictate it. In the final analysis, the ultimate decision whether to suspend benefits rests with the insurer." *Fleming,* 878 F.Supp. at 861.

It seems clear that the later three cases decided since *Baksalary* have found the action of the private insurers in connection with state workers' compensation laws to be more analogous to the private creditor seeking judgment than to the private creditor seeking execution upon a judgment. The former involves mere acquiescence while the latter, overt state assistance. Plaintiffs suggest throughout their brief that the Bureau reviews requests for UR both for substantive and procedural compliance with the statute. The difference between the two is not clear in the context of plaintiffs' argument. One thing is clear and that is that the Bureau makes no determination as to whether the medical costs are reasonable or necessary. That, it seems to me, is the substantive matter involved in a request for UR.

Appendix E

In coming to the ultimate decision in this case, I find some comfort in the reference made by the court in *Groman v. Township of Manalapan*, 47 F.3d 628, 639 (3d Cir. 1995) as follows:

> We note initially that, as one commentator has observed: Imposing categories and labels on the court's different approaches to state action issues is somewhat arbitrary and potentially misleading. The court seldom describes its decisions as creating a structure of discrete state action theories. Rather, the court's decisions follow the more traditional judicial style of deciding each case based on the facts of the case, guided by similarly fact-specific decisions of the past. In addition, the court uses different phrases to refer to the same or similar theories. . . . Nonetheless, the court's state action decisions do create some clearly distinguishable approaches to the state action issue. Henry C. Strickland, *The State Action Doctrine and the Rehnquist Court*, 18 Hastings Const. L.Q. 587, 596-97 (1991) (citations omitted).

My analysis of one of the objects of the Constitution stated in *Edmonson*, the relevant case law and the development and refinement of it since *Baksalary*, leads me to conclude that the insurers in this case are not state actors, primarily because the decision to cease paying medical benefits is entirely up to the insurer acting independent of any state involvement whatsoever. The state takes no substantive step to promote, support or encourage the decision of the insurer; and after the decision is made, the state takes no action which influences the ultimate substantive determination as to whether benefits are payable or not. The state does not significantly assist private actors when it merely provides a remedy, albeit complete with authorized

forms and regulations. The state's acceptance and routing of forms completed in accordance with its instructions, in essence, it seems to me, involves acquiescence and not compulsion on the part of the state.

B. School District Defendant.

As to the school district's motion to dismiss, the mere fact that it has obtained the services of a third party administrator to provide medical claims management service does not necessarily relieve it of responsibility for constitutional violations of that third party. (We are assuming, without having decided, that the third party administrators' use of UR violates plaintiffs' constitutional rights.) In this case, the school board has elected to fulfill its medical benefit obligations on its own rather than to secure an insurance carrier. To what extent the practices and policies of the school board both with regard to payment of medical benefits and to the role of the third party administrator in the determination thereof play a part in bringing about the challenged activity (request for UR) is not sufficiently clear for me to find as a matter of law in the school board's favor.

While the school district argues otherwise, I cannot determine on the present state of the record if it has promulgated any policy or custom, or coerced or exerted significant pressure on the third party administrator so as to compel the challenged activity. For example, the preliminary request for proposal for the claims management service devotes a section to interaction with school officials, including a monthly review of serious cases with staff from the school district. Does this involve any policy or custom? By the same token, I cannot grant plaintiffs' motion for summary judgment as to the state action issue. More discovery is needed relative to practices and policies of the school board.

An order follows.

Appendix E

IN THE UNITED STARES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

CIVIL ACTION

NO. 95-201

DELORES SCOTT SULLIVAN, et al.,

Plaintiffs,

v.

ROBERT BARRETT, et al.,

Defendants,

ORDER

AND NOW, this 24th day of January, 1996, upon consideration of defendants American Manufacturers Mutual Insurance Company, Insurance Company of North America, Continental Casualty Company, USF&G Insurance Company and Zurich American Insurance Company's Motion to Dismiss Complaint (Docket No. 10), it is hereby ORDERED and DECREED that said Motion is GRANTED.

The Motions of the School District of Philadelphia to Dismiss Complaint (Docket Nos. 11, 12 and 14) are DENIED.

The plaintiffs' Motion for Partial Summary Judgment (Docket No. 25) is DENIED.

BY THE COURT:
Ronald L. Buckwalter, J.
RONALD L. BUCKWALTER, J.

APPENDIX F — STATUTES AND REGULATIONS INVOLVED

77 P.S. § 501

§ 501. Insurance of payment of compensation by employer; appeal from denial of exemption; effect of failure to insure; penalty; remedies for failure to secure payment

(a)(1) Every employer liable under this act to pay compensation shall insure the payment of compensation in the State Workmen's Insurance Fund, or in any insurance company, or mutual association or company, authorized to insure such liability in this Commonwealth, unless such employer shall be exempted by the department from such insurance. Such insurer shall assume the employer's liability hereunder and shall be entitled to all of the employer's immunities and protection hereunder except, that whenever any employer shall have purchased insurance to provide benefits under this act to persons engaged in domestic service, neither the employer nor the insurer may invoke the provisions of section 321[1] as a defense. An employer desiring to be exempt from insuring the whole or any part of his liability for compensation shall make application to the department, showing his financial ability to pay such compensation, whereupon the department, if satisfied of the applicant's financial ability, shall, upon the payment of a fee of five hundred dollars ($500), issue to the applicant a permit authorizing such exemption.

(2) In securing the payment of benefits, the department shall require an employer wishing to self-insure its liability and a group of employers approved to pool their liabilities under Article VIII to establish sufficient security by posting a bond or other security,

1. 77 P.S. § 676.

including letters of credit drawn on commercial banks with a Thomson Bank Watch rating of B/C or better or a Thomson Bank Watch score of 2.5 or better for the bank or its holding company or with a CD rating of BBB or better by Standard and Poor's. This paragraph shall not apply to the Commonwealth or its political subdivisions.

(3) The department shall establish a period of twelve (12) calendar months to begin and end at such times as the department shall prescribe, which shall be known as the annual exemption period. Unless previously revoked, all permits issued under this section shall expire and terminate on the last day of the annual exemption period for which they were issued. Permits issued under this act shall be renewed upon the filing of an application, and the payment of a renewal fee of one hundred dollars ($100.00). The department may, from time to time, require further statements of the financial ability of such employer, and, if at any time such employer appear no longer able to pay compensation, shall revoke its permit granting exemption, in which case the employer shall immediately subscribe to the State Workmen's Insurance Fund, or insure his liability in any insurance company or mutual association or company, as aforesaid.

(b) Any employer who fails to comply with the provisions of this section for every such failure, shall, upon conviction in the court of common pleas, be guilty of a misdemeanor of the third degree. If the failure to comply with this section is found by the court to be intentional, the employer shall be guilty of a felony of the third degree. Every day's violation shall constitute a separate offense. A judge of the court of common pleas may, in addition to imposing fines and imprisonment, include restitution in his order: Provided, That there is an injured employe who has obtained an award of compensation. The amount of restitution

shall be limited to that specified in the award of compensation. It shall be the duty of the department to enforce the provisions of this section; and it shall investigate all violations that are brought to its notice and shall institute prosecutions for violations thereof. All fines recovered under the provisions of this section shall be paid to the department, and by it paid into the State Treasury and appropriated to the Office of Attorney General if the prosecutor is the Attorney General and paid to the operating fund of the county in which the district attorney is elected if the prosecutor is a district attorney.

(c) In any proceeding against an employer under this section, a certificate of non-insurance issued by the official Workmen's Compensation Rating and Inspection Bureau and a certificate of the department showing that the defendant has not been exempted from obtaining insurance under this section, shall be prima facie evidence of the facts therein stated.

(d) When any employer fails to secure the payment of compensation under this act as provided in sections 305 and 305.2,[2] the injured employe or his dependents may proceed either under this act or in a suit for damages at law as provided by article II.[3]

(e) Every employer shall post a notice at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for the treatment of injured employes or for the administration of first aid, containing:

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2. 77 P.S. §§ 501, 411.2.

3. 77 P.S. § 41 et seq.

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(1) Either the name of the employer's carrier and the address and telephone number of such carrier or insurer or, if the employer is self-insured, the name, address and telephone number of the person to whom claims or requests for information are to be addressed.

(2) The following statement: "Remember, it is important to tell your employer about your injury."

The notice shall be posted in prominent and easily accessible places at the site of employment, including such places as are used for treatment and first aid of injured employes. Such a listing shall contain the information as specified in this section, typed or printed on eight and one-half inch by eleven inch or eight and one-half inch by thirteen inch paper in standard size type or larger.

Amended 1993, July 2, P.L. 190. No. 44, § 7, effective in 60 days; 1996, June 24, P.L. 350, No. 57, § 3, effective in 60 days.

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77 P.S. § 531

MEDICAL SERVICES

§ 531. Surgical and medical services and supplies; designation by employer; artificial limb or eye

The following schedule of compensation is hereby established:

(1) The employer shall provide payment for reasonable surgical and medical services, services rendered by duly licensed practitioners of the healing arts, medicines, and supplies, as and when needed: Provided, That if a list of at least five designated physicians or other duly licensed practitioners of the healing arts or a combination thereof is provided by the employer, the employe shall be required to visit one of the physicians or other practitioners so designated and shall continue to visit the same or another physician or practitioner for a period of fourteen days from the date of the first visit. Subsequent treatment may be provided by any physician or any other duly licensed practitioner of the healing arts or a combination thereof, of the employes own choice, and such treatment shall be paid for by the employer. Any employe who next following the termination of the fourteen-day period is provided treatment from a physician or other duly licensed practitioner of the healing arts who is not one of the physicians or practitioners designated by the employer, shall notify the employer within five days of the first visit to said physician or practitioner. However, if the employe fails to so notify the employer, the employe shall suffer no loss of rights or benefits to which he is otherwise entitled under the act.

(2) If and only if the employer has designated at least five physicians or other duly licensed practitioners of the healing arts

or a combination thereof as permitted by the preceding paragraph, the following reporting provisions shall apply. Nothing in the following paragraphs shall eliminate rights of the employer to obtain all records and data as permitted under any other sections of this act.

(i) The physician or other duly licensed practitioner of the healing arts shall be required to file periodic reports with the employer on a form prescribed by the department which shall include, where pertinent, history, diagnosis, treatment, prognosis and physical findings. The report shall be filed within twenty-one days of commencing treatment and at least once a month thereafter, as long as treatment continues. The employer shall not be liable to pay for such treatment until a report has been filed.

(ii) The employer shall have the right to petition the department for review of the necessity or frequency of treatment or reasonableness of fees for services provided by a physician or other duly licensed practitioner of the healing arts. Such a petition shall in no event act as supersedeas, and during the pendency of any such petition the employer shall pay all medical bills if the physician or other practitioner of the healing arts files a report or reports as required by subparagraph (I) of paragraph (2) of this subsection.

(3) After an employe has elected to be treated by a physician or other duly licensed practitioner of the healing arts who is not one of the physicians or practitioners designated by the employer, he may thereafter elect to be treated by another physician or other duly licensed practitioner of the healing arts upon notice to his employer: Provided, however, That no such notice shall be required in emergencies, or in cases of referrals by one physician or practitioner to another physician or practitioner or if the new

physician or practitioner makes a timely report to the employer within twenty-one days after commencing treatment.

(4) In addition to the above service, the employer shall provide payment for medicines and supplies, hospital treatment, services and supplies and orthopedic appliances, and prostheses. The cost for such hospital treatment, service and supplies shall not in any case exceed the prevailing charge in the hospital for like services to other individuals. If the employe shall refuse reasonable services of duly licensed practitioners of the healing arts, surgical, medical and hospital services, treatment, medicines and supplies, he shall forfeit all rights to compensation for any injury or any increase in his incapacity shown to have resulted from such refusal. Whenever an employe shall have suffered the loss of a limb, part of a limb, or an eye, the employer shall also provide payment for an artificial limb or eye or other prostheses of a type and kind recommended by the doctor attending such employe in connection with such injury and any replacements for an artificial limb or eye which the employe may require at any time thereafter, together with such continued medical care as may be prescribed by the doctor attending such employe in connection with such injury as will as such training as may be required in the proper use of such prostheses. The provisions of this section shall apply in injuries whether or not loss of earning power occurs. If hospital confinement is required, the employe shall be entitled to semi-private accommodations but if no such facilities are available, regardless of the patient's condition, the employer, not the patient, shall be liable for the additional costs for the facilities in a private room.

(5) The payment by an insurer for any medical, surgical or hospital services or supplies after any statute of limitations provided for in this act shall have expired shall not act to reopen

for review the compensation rights for purposes of such limitations.

1915, June 2, P.L. 735, art. III, § 301(e). Amended 1919, June 26, P.L. 642, § 1; 1927, April 13, P.L. 186, § 1. reenacted and amended 1937, June 4, P.L. 1552, § 1. Reenacted, renumbered as § 306(f) and amended 1939, June 21, P.L. 520, § 1. Amended 1945, May 18, P.L. 671, § 1; 1949, May 14, P.L. 1369, § 1; 1953, Aug. 24, P.L. 1382, § 1; 1956, Feb. 28, P.L. (1955) 1120, § 1; 1959, Dec. 28, P.L. 2034, § 2, effective Jan. 30, 1960; 1961, Aug. 8, P.L. 984, § 1; 1961, Sept. 30, P.L. 1762, § 1; 1965, Dec. 31, P.L. 1284, § 3, effective Jan. 1, 1966; 1972, March 29, P.L. 159, No. 61, § 12, effective May 1, 1972; 1974. Dec. 5, P.L. 782, No. 263, § 10, effective in 60 days; 1978, July 1, P.L. 692, No. 119, § 1.

Appendix F

77 P.S. § 531

§ 531. Surgical and medical services and supplies; designation by employer; artificial limb or eye

(1)(i) The employer shall provide payment in accordance with this section for reasonable surgical and medical services, services rendered by physicians or other health care providers, including an additional opinion when invasive surgery may be necessary, medicines and supplies, as and when needed. Provided an employer establishes a list of at least six designated health care providers, no more than two of whom may be a coordinated care organization and no fewer than three of whom shall be physicians, the employe shall be required to visit one of the physicians or other health care providers so designated and shall continue to visit the same or another designated physician or health care provider for a period of ninety (30) days from the date of the first visit. Provided, however, That the employer shall not include on the list a physician or other health care provider who is employed, owned or controlled by the employer or the employer's insurer unless employment, ownership or control is disclosed on the list. Should the employe not comply with the foregoing, the employer will be relieved from liability for the payment for the services rendered during such applicable period. It shall be the duty of the employer to provide a clearly written notification of the employe's rights and duties under this section to the employe. The employer shall further ensure that the employe has been informed and that he understands these rights and duties. This duty shall be evidenced only by the employe's written acknowledgment of having been informed and having understood his rights and duties. Any failure of the employer to provide and evidence such notification shall relieve the employe from any notification duty owed, notwithstanding any provision of this act

to the contrary, and the employer shall remain liable for all rendered treatment. Subsequent treatment may be provided by any health care provider of the employe's own choice. Any employe who, next following termination of the applicable period, is provided treatment from a nondesignated health care provider shall notify the employer within five days of the first visit to said health care provider. Failure to so notify the employer will relieve employer from liability for the payment for the services rendered prior to appropriate notice if such services are determined pursuant to paragraph (6) to have been unreasonable or unnecessary.

(ii) In addition to the above service, the employer shall provide payment for medicines and supplies, hospital treatment, services and supplies and orthopedic appliances, and prostheses in accordance with this section. Whenever an employe shall have suffered the loss of a limb, part of a limb, or an eye, the employer shall also provide for an artificial limb or eye or other prostheses of a type and kind recommended by the doctor attending such employe in connection with such injury and any replacements for an artificial limb or eye which the employe may require at any time thereafter, together with such continued medical care as may be prescribed by the doctor attending such employe in connection with such injury as well as such training as may be required in the proper use of such prostheses. The provisions of this section shall apply to injuries whether or not loss of earning power occurs. If hospital confinement is required, the employe shall be entitled to semiprivate accommodations, but, if no such facilities are available, regardless of the patient's condition, the employer, not the patient, shall be liable for the additional costs for the facilities in a private room.

(iii) Nothing in this section shall prohibit an insurer or an employer from contracting with any individual, partnership,

association or corporation to provide case management and coordination of services with regard to injured employes.

(2) Any provider who treats an injured employe shall be required to file periodic reports with the employer on a form prescribed by the department which shall include, where pertinent, history, diagnosis, treatment, prognosis and physical findings. The report shall be filed within ten (10) days of treatment and at least once a month thereafter as long as treatment continues. The employer shall not be liable to pay for such treatment until a report has been filed.

(3)(i) For purposes of this clause, a provider shall not require, request or accept payment for treatment, accommodations, products or services in excess of one hundred thirteen per centum of the prevailing charge at the seventy-fifth percentile; one hundred thirteen per centum of the applicable fee schedule, the recommended fee or the inflation index charge; one hundred thirteen per centum of the DRG payment plus pass-through costs and applicable cost or day outliers; or one hundred thirteen per centum of any other Medicare reimbursement mechanism, as determined by the Medicare carrier or intermediary, whichever pertains to the specialty service involved, determined to be applicable in this Commonwealth under the Medicare program for comparable services rendered. If the commissioner determines that an allowance for a particular provider group or service under the Medicare program is not reasonable, it may adopt, by regulation, a new allowance. If the prevailing charge, fee schedule, recommended fee, inflation index charge, DRG payment or any other reimbursement has not been calculated under the Medicare program for a particular treatment, accommodation, product or service, the amount of the payment may exceed eighty per centum of the charge most often made by providers of similar training,

experience, and licensure for a specific treatment, accommodation, product or service in the geographic area where the treatment, accommodation, product or service is provided.

(ii) Commencing on January 1, 1995, the maximum allowance for a health care service covered by subparagraph (i) shall be updated as of the first day of January of each year. The update, which shall be applied to all services performed after January 1 of each year, shall be equal to the percentage change in the Statewide average weekly wage. Such updates shall be cumulative.

(iii) Notwithstanding any other provision of law, it is unlawful for a provider to refer a person for laboratory, physical therapy, rehabilitation, chiropractic, radiation oncology, psychometric, home infusion therapy or diagnostic imaging, goods or services pursuant to this section if the provider has a financial interest with the person or in the entity that receives the referral. It is unlawful for a provider to enter into an arrangement or scheme such as a cross-referral arrangement, which the provider knows or should know has a principal purpose of assuring referrals by the provider to a particular entity which, if the provider directly made referrals to such entity, would be in violation of this section. No claim for payment shall be presented by an entity to any individual, third-party payer or other entity for a service furnished pursuant to a referral prohibited under this section.

(iv) The secretary shall retain the services of an independent consulting firm to perform an annual accessibility study of health care provided under this act. The study shall include information as to whether there is adequate access to quality health care and products for injured workers and a review of the information that is provided. If the secretary determines based on this study that as a result of the health care fee schedule there is not sufficient

access to quality health care or products for persons suffering injuries covered by this act, the secretary may recommend to the commissioner the adoption of regulations providing for a new allowance.

(v) An allowance shall be reviewed for reasonableness whenever the commissioner determines that the use of the allowance would result in payments more than ten per centum lower than the average level of reimbursement the provider would receive from coordinated care insurers, including those entities subject to the act of December 29, 1972 (P.L. 1701, No. 364), known as the "Health Maintenance Organization Act,"[1] and those entities known as preferred provider organizations which are subject to section 630 of the Insurance Company Law of 1921[2] for like treatments, accommodations, products or services. In making this determination, the commissioner shall consider the extent to which allowances applicable to other providers under this section deviate from the reimbursement such providers would receive from coordinated care insurers. Any information received as a result of this subparagraph shall be confidential.

(vi) The reimbursement for prescription drugs and professional pharmaceutical services shall be limited to one hundred ten per centum of the average wholesale price of the product.

(vii) The applicable Medicare fee schedule shall include fees associated with all permissible procedure codes. If the Medicare fee schedule also includes a larger grouping of procedure codes and corresponding charges than are specifically reimbursed by

1. 40 P.S. § 1551 et seq.

2. 40 P.S. § 764a.

Medicare, a provider may use these codes, and corresponding charges shall be paid by insurers or employers. If a Medicare code exists for application to a specific provider specialty, that code shall be used.

(viii) A provider shall not fragment or unbundle charges imposed for specific care except as consistent with Medicare. Changes to a provider's codes by an insurer shall be made only as consistent with Medicare and when the insurer has sufficient information to make the changes and following consultation with the provider.

(4) Nothing in this act shall prohibit the self-insured employer, employer or insurer from contracting with a coordinated care organization for reimbursement levels different from those identified above.

(5) The employer or insurer shall make payment and providers shall submit bills and records in accordance with the provisions of this section. All payments to providers for treatment provided pursuant to this act shall be made within thirty (30) days of receipt of such bills and records unless the employer or insurer disputes the reasonableness or necessity of the treatment provided pursuant to paragraph (6). A provider who has submitted the reports and bills required by this section and who disputes the amount or timeliness of the payment from the employer or insurer shall file an application for fee review with the department. Within thirty (30) days of the filing of such an application, the department shall render an administrative decision.

(6) Except in those cases in which a workers' compensation judge asks for an opinion from peer review under section 420,[3]

3. 77 P.S. §§ 831, 832.

disputes as to reasonableness or necessity of treatment by a health care provider shall be resolved in accordance with the following provisions;

(i) The reasonableness or necessity of all treatment provided by a health care provider under this act may be subject to prospective, concurrent or retrospective utilization review at the request of an employe, employer or insurer. The department shall authorize utilization review organizations to perform utilization review under this act. Organizations not authorized by the department may not engage in such utilization review.

(ii) The utilization review organization shall issue a written report of its findings and conclusions within thirty (30) days of a request. If the provider, employer, employer, employe or insurer disagree with the finding of the utilization review organization, a request for reconsideration must be filed no later than thirty (30) days after receipt of the utilization review report. The request for reconsideration must be in writing.

(iii) The employer or the insurer shall pay the cost of the utilization review. The party which does not prevail on reconsideration of an initial review shall bear the costs of such reconsideration.

(iv) If the provider, employer, employe or insurer disagrees with the finding of the utilization review organization, a petition for review by the department must be filed within thirty (30) days after receipt of the reconsideration report. The department shall assign the petition to a workers' compensation judge for a hearing.

(7) A provider shall not hold an employe liable for costs related to care or service rendered in connection with a

compensable injury under this act. A provider shall not bill or otherwise attempt to recover from the employe the difference between the provider's charge and the amount paid by the employer or the insurer.

(8) If the employe shall refuse reasonable services of health care providers, surgical, medical and hospital services, treatment, medicines and supplies, he shall forfeit all rights to compensation for any injury or increase in his incapacity shown to have resulted from such refusal.

(9) The payment by an insurer or employer for any medical, surgical, or hospital services or supplies after any statute of limitations provided for in this act shall have expired shall not act to reopen or revive the compensation rights for purposes of such limitations.

(10) If acute care is provided in an acute care facility to a patient with an immediately life threatening or urgent injury by a Level I or Level II trauma center accredited by the Pennsylvania Trauma Systems Foundation under the act of July 3, 1985 (P.L. 164, No. 45), known as the "Emergency Medical Services Act,"[4] or to a burn injury patient by a burn facility which meets all the service standards of the American Burn Association, or if basic or advanced life support services, as defined and licensed under the "Emergency Medical Services Act," are provided, the amount of payment shall be the usual and customary charge.

Renumbered as § 306(f.1) and amended 1993, July 2, P.L. 190, No. 44, § 8, effective in 60 days.

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4. 77 P.S. § 6921 et seq.

Appendix F

77 P.S. § 531

§ 531. Surgical and medical services and supplies; designation by employer; artificial limb or eye

(1)(i) The employer shall provide payment in accordance with this section for reasonable surgical and medical services, services rendered by physicians or other health care providers, including an additional opinion when invasive surgery may be necessary, medicines and supplies, as and when needed. Provided an employer establishes a list of at least six designated health care providers, no more than four of whom may be a coordinated care organization and no fewer than three of whom shall be physicians, the employe shall be required to visit one of the physicians or other health care providers so designated and shall continue to visit the same or another designated physician or health care provider for a period of ninety (90) days from the date of the first visit. Provided, however, That the employer shall not include on the list a physician or other health care provider who is employed, owned or controlled by the employer or the employer's insurer unless employment, ownership or control is disclosed on the list. Should invasive surgery for an employe be prescribed by a physician or other health care provider so designated by the employer, the employe shall be permitted to receive an additional opinion from any health care provider of the employe's own choice. If the additional opinion differs from the opinion provided by the physician or health care provider so designated by the employer, the employe shall determine which course of treatment to follow: Provided, That the second opinion provides a specific and detailed course of treatment. If the employe chooses to follow the procedures designated in the second opinion, such procedures shall be performed by one of the physicians or other health care providers so designated by

the employer for a period of ninety (90) days from the date of the visit to the physician or other health care provider of the employe's own choice. Should the employe not comply with the foregoing, the employer will be relieved from liability for the payment for the services rendered during such applicable period. It shall be the duty of the employer to provide a clearly written notification of the employe's rights and duties under this section to the employe. The employer shall further ensure that the employe has been informed and that he understands these rights and duties. This duty shall be evidenced only by the employe's written acknowledgment of having been informed and having understood his rights and duties. Any failure of the employer to provide and evidence such notification shall relieve the employe from any notification duty owed, notwithstanding any provision of this act to the contrary, and the employer shall remain liable for all rendered treatment. Subsequent treatment may be provided by any health care provider of the employe's own choice. Any employe who, next following termination of the applicable period, is provided treatment from a nondesignated health care provider shall notify the employer within five (5) days of the first visit to said health care provider. Failure to so notify the employer will relieve employer from liability for the payment for the services rendered prior to appropriate notice if such services are determined pursuant to paragraph (6) to have been unreasonable or unnecessary.

(ii) In addition to the above service, the employer shall provide payment for medicines and supplies, hospital treatment, services and supplies and orthopedic appliances, and prostheses in accordance with this section. Whenever an employe shall have suffered the loss of a limb, part of a limb, or an eye, the employer shall also provide for an artificial limb or eye or other prostheses of a type and kind recommended by the doctor attending such

employe in connection with such injury and any replacements for an artificial limb or eye which the employe may require at any time thereafter, together with such continued medical care as may be prescribed by the doctor attending such employe in connection with such injury as well as such training as may be required in the proper use of such prostheses. The provisions of this section shall apply to injuries whether or not loss of earning power occurs. If hospital confinement is required, the employe shall be entitled to semiprivate accommodations, but, if no such facilities are available, regardless of the patient's condition, the employer, not the patient, shall be liable for the additional costs for the facilities in a private room.

(iii) Nothing in this section shall prohibit an insurer or an employer from contracting with any individual, partnership, association or corporation to provide case management and coordination of services with regard to injured employes.

(2) Any provider who treats an injured employe shall be required to file periodic reports with the employer on a form prescribed by the department which shall include, where pertinent, history, diagnosis, treatment, prognosis and physical findings. The report shall be filed within ten (10) days of treatment and at least once a month thereafter as long as treatment continues. The employer shall not be liable to pay for such treatment until a report has been filed.

(3)(i) For purposes of this clause, a provider shall not require, request or accept payment for treatment, accommodations, products or services in excess of one hundred thirteen per centum of the prevailing charge at the seventy-fifth percentile; one hundred thirteen per centum of the applicable fee schedule, the recommended fee or the inflation index charge; one hundred

thirteen per centum of the DRG payment plus pass-through costs and applicable cost or day outliers; or one hundred thirteen per centum of any other Medicare reimbursement mechanism, as determined by the Medicare carrier or intermediary, whichever pertains to the specialty service involved, determined to be applicable in this Commonwealth under the Medicare program for comparable services rendered. If the commissioner determines that an allowance for a particular provider group or service under the Medicare program is not reasonable, it may adopt, by regulation, a new allowance. If the prevailing charge, fee schedule, recommended fee, inflation index charge, DRG payment or any other reimbursement has not been calculated under the Medicare program for a particular treatment, accommodation, product or service, the amount of the payment may exceed eighty per centum of the charge most often made by providers of similar training, experience, and licensure for a specific treatment, accommodation, product or service in the geographic area where the treatment, accommodation, product or service is provided.

(ii) Commencing on January 1, 1995, the maximum allowance for a health care service covered by subparagraph (i) shall be updated as of the first day of January of each year. The update, which shall be applied to all services performed after January 1 of each year, shall be equal to the percentage change in the Statewide average weekly wage. Such updates shall be cumulative.

(iii) Notwithstanding any other provision of law, it is unlawful for a provider to refer a person for laboratory, physical therapy, rehabilitation, chiropractic, radiation oncology, psychometric, home infusion therapy or diagnostic imaging, goods or services pursuant to this section if the provider has a financial interest with the person or in the entity that receives the referral. It is unlawful for a provider to enter into an arrangement or scheme

such as a cross referral arrangement, which the provider knows or should know has a principal purpose of assuring referrals by the provider to a particular entity which, if the provider directly made referrals to such entity, would be in violation of this section. No claim for payment shall be presented by an entity to any individual, third-party payer or other entity for a service furnished pursuant to a referral prohibited under this section.

(iv) The secretary shall retain the services of an independent consulting firm to perform an annual accessibility study of health care provided under this act. The study shall include information as to whether there is adequate access to quality health care and products for injured workers and a review of the information that is provided. If the secretary determines based on this study that as a result of the health care fee schedule there is not sufficient access to quality health care or products for persons suffering injuries covered by this act, the secretary may recommend to the commissioner the adoption of regulations providing for a new allowance.

(v) An allowance shall be reviewed for reasonableness whenever the commissioner determines that the use of the allowance would result in payments more than ten per centum lower than the average level of reimbursement the provider would receive from coordinated care insurers, including those entities subject to the act of December 29, 1972 (P.L. 1701, No. 364).[1] known as the "Health Maintenance Organization Act," and those entities known as preferred provider organizations which are subject to section 630 of the Insurance Company Law of 1921[2] for like treatments, accommodations, products or services. In

1. 40 P.S. § 1551 et seq.

2. 40 P.S. § 764a.

making this determination, the commissioner shall consider the extent to which allowances applicable to other providers under this section deviate from the reimbursement such providers would receive from coordinated care insurers. Any information received as a result of this subparagraph shall be confidential.

(vi) The reimbursement for prescription drugs and professional pharmaceutical services shall be limited to one hundred ten per centum of the average wholesale price of the product.

(vii) The applicable Medicare fee schedule shall include fees associated with all permissible procedure codes. If the Medicare fee schedule also includes a larger grouping of procedure codes and corresponding charges than are specifically reimbursed by Medicare, a provider may use these codes, and corresponding charges shall be paid by insurers or employers. If a Medicare code exists for application to a specific provider specialty, that code shall be used.

(viii) A provider shall not fragment or unbundle charges imposed for specific care except as consistent with Medicare. Changes to a provider's codes by an insurer shall be made only as consistent with Medicare and when the insurer has sufficient information to make the changes and following consultation with the provider.

(4) Nothing in this act shall prohibit the self-insured employer, employer or insurer from contracting with a coordinated care organization for reimbursement levels different from those identified above.

(5) The employer or insurer shall make payment and providers shall submit bills and records in accordance with the provisions of this section. All payments to providers for treatment provided pursuant to this act shall be made within thirty (30) days of receipt of such bills and records unless the employer or insurer disputes the reasonableness or necessity of the treatment provided pursuant to paragraph (6). The nonpayment to providers within thirty (30) days for treatment for which a bill and records have been submitted shall only apply to that particular treatment or portion thereof in dispute; payment must be made timely for any treatment or portion thereof not in dispute. A provider who has submitted the reports and bills required by this section and who disputes the amount or timeliness of the payment from the employer or insurer shall file an application for fee review with the department no more than thirty (30) days following notification of a disputed treatment or ninety (90) days following the original billing date of treatment. If the insurer disputes the reasonableness and necessity of the treatment pursuant to paragraph (6), the period for filing an application for fee review shall be tolled as long as the insurer has the right to suspend payment to the provider pursuant to the provisions of this paragraph. Within thirty (30) days of the filing of such an application, the department shall render an administrative decision.

(6) Except in those cases in which a workers' compensation judge asks for an opinion from peer review under section 420,[3] disputes as to reasonableness or necessity of treatment by a health care provider shall be resolved in accordance with the following provisions;

(i) The reasonableness or necessity of all treatment provided by a health care provider under this act may be subject to

3. 77 P.S. §§ 831, 832.

prospective, concurrent or retrospective utilization review at the request of an employe, employer or insurer. The department shall authorize utilization review organizations to perform utilization review under this act. Utilization review of all treatment rendered by a health care provider shall be performed by a provider licensed in the same profession and having the same or similar speciality as that of the provider of the treatment under review. Organizations not authorized by the department may not engage in such utilization review.

(ii) The utilization review organization shall issue a written report of its findings and conclusions within thirty (30) days of a request.

(iii) The employer or the insurer shall pay the cost of the utilization review.

(iv) If the provider, employer, employe or insurer disagrees with the finding of the utilization review organization, a petition for review by the department must be filed within thirty (30) days after receipt of the report. The department shall assign the petition to a workers' compensation judge for a hearing or for an informal conference under section 402.1.[4] The utilization review report shall be part of the record before the workers' compensation judge. The workers' compensation judge shall consider the utilization review report as evidence but shall not be bound by the report.

(7) A provider shall not hold an employe liable for costs related to care or service rendered in connection with a compensable injury under this act. A provider shall not bill or

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4. 77 P.S. § 711.1.

otherwise attempt to recover from the employe the difference between the provider's charge and the amount paid by the employer or the insurer.

(8) If the employe shall refuse reasonable services of health care providers, surgical, medical and hospital services, treatment, medicines and supplies, he shall forfeit all rights to compensation for any injury or increase in his incapacity shown to have resulted from such refusal.

(9) The payment by an insurer or employer for any medical, surgical, or hospital services or supplies after any statute of limitations provided for in this act shall have expired shall not act to reopen or revive the compensation rights for purposes of such limitations.

(10) If acute care is provided in an acute care facility to a patient with an immediately life threatening or urgent injury by a level I or Level II trauma center accredited by the Pennsylvania Trauma Systems Foundation under the act of July 3, 1985 (P.L. 164, No. 45),[5] known as the "Emergency Medical Services Act," or to a burn injury patient by a burn facility which meets all the service standards of the American Burn Association, or if basic or advanced life support services, as defined and licensed under the "Emergency Medical Services Act," are provided, the amount of payment shall be the usual and customary charge.

Renumbered as § 306(f.1) and amended 1993, July 2, P.L. 190, No. 44, § 8, effective in 60 days. Amended 1996, June 24, P.L. 350, No. 57, § 4, effective in 60 days.

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5. 35 P.S. § 6921 et seq.

Appendix F

77 P.S. § 996

§ 996. Contested cases regarding liability; attorney's fees and other costs; limitation and calculation

In any contested case where the insurer has contested liability in whole or in part, the employe or his dependent, as the case may be, in whose favor the matter at issue has been finally determined shall be awarded, in addition to the award for compensation, a reasonable sum for costs incurred for attorney's fee, witnesses, necessary medical examination, and the value of unreimbursed lost time to attend the proceedings: Provided, That cost for attorney fees may be excluded when a reasonable basis for the contest has been established. And provided further That if the insurer has paid or rendered payment of compensation and the controversy relates to the amount of compensation due, costs for attorney's fee shall be based only on the difference between the final award of compensation and the compensation paid or tendered by the insurer.

In contested cases involving petitions to terminate, reinstate, increase, reduce or otherwise modify compensation awards, agreements or other payment arrangements or to set aside final receipts, where the contested issue, in whole or part, is resolved in favor of the claimant, the claimant shall be entitled to an award of reasonable costs as herinabove set forth.

1915, June 2, P.L. 736, art. IV, § 440, added 1972, feb. 8, P.L. 25, No. 12, § 3.

Appendix F

77 P.S. § 996

§ 996. Contested cases regarding liability; attorney's fees and other costs; limitation and calculation

(a) In any contested case where the insurer has contested liability in whole or in part, including contested cases involving petitions to terminate, reinstate, increase, reduce or otherwise modify compensation awards, agreements or other payment arrangements or to set aside final receipts, the employe or his dependent, as the case may be, in whose favor the matter at issue has been finally determined in whole or in part shall be awarded, in addition to the award for compensation, a reasonable sum for costs incurred for attorney's fee, witnesses, necessary medical examination, and the value of unreimbursed lost time to attend the proceedings: Provided, That cost for attorney fees may be excluded when a reasonable basis for the contest has been established by the employer or the insurer.

(b) If counsel fees are awarded and assessed against the insurer or employer, then the workers' compensation judge must make a finding as to the amount and the length of time for which such counsel fee is payable based upon the complexity of the factual and legal issues involved, the skill required, the duration of the proceedings and the time and effort required and actually expended. If the insurer has paid or tendered payment for compensation and the controversy relates to the amount of compensation due, costs for attorney's fee shall be based only on the difference between the final award of compensation and the compensation paid or tendered by the insurer.

Amended 1993, July 2, P.L. 190, No. 44, § 17, effective in 60 days; 1996, June 24, P.L. 350, No. 57, § 19, effective in 60 days.

Appendix F

77 P.S. § 999

§ 999. Denial of supersedeas, reimbursement; appeal; workmen's compensation supersedeas fund created; assessments, notice, objections and findings; department's records; evidence; disbursements

(a) If, in any case in which a supersedeas has been requested and denied under the provisions of section 413 or section 430,[1] payments of compensation are made as a result thereof and upon the final outcome of the proceedings, it is determined that such compensation was not, in fact, payable, the insurer who has made such payments shall be reimbursed therefor. Application for reimbursement shall be made to the department on forms prescribed by the department and furnished by the insurer. Applications may be assigned to a workmen's compensation referee for a hearing and determination of eligibility for reimbursement pursuant to this act. An appeal shall lie in the manner and on the grounds provided in section 423 of this act,[2] from any allowance or disallowance of reimbursement under this section.

1915, June 2, P.L. 736, art. IV, § 443, added 1972, Feb. 8, P.L. 25, No. 12, § 3. Amended 1975, July 30, P.L. 139, No. 70, § 1, imd. effective.

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1. 77 P.S. §§ 771 to 774.1 and 971.

2. 77 P.S. §§ 853, 854

Appendix F

PENNSYLVANIA BUREAU OF WORKERS' COMPENSATION RULES AND REGULATIONS

34 PA. CODE § 121.23

§ 121.23. The supersedeas fund.

(a) Pursuant to section 443 of the act as amended July 30, 1975, (77 P.S. § 999) each insurer shall be annually assessed an amount as determined by the following formula:

$$\frac{\text{Amount of Compensation Paid by an Insurer during the Preceding Year}}{\text{Total Amount of Compensation Paid by All insurers during the Preceding Year}} \times \text{The Amount of Supersedeas Payments Made during the Preceding Year}$$

(b) Applications for reimbursement shall be filed directly with the Bureau of Occupational Injury and Disease Compensation, Department of Labor and Industry, Harrisburg, Pennsylvania 17120, on Form OIDC-662, Request for Supersedeas Fund Reimbursement. All applications shall be promptly assigned to a referee of the Department who shall make a determination as to eligibility for reimbursement, after affording all parties in interest, and the Commonwealth, the opportunity for a hearing.

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Appendix F

NEW PENNSYLVANIA BUREAU OF WORKERS' COMPESATION RULES AND REGULATIONS

34 PA. CODE § 127.208

BILLING TRANSACTION

§ 127.208. Time for payment of medical bills.

(a) Payments for treatment rendered under the act shall be made within 30 days of receipt of the bill and report submitted by the provider.

(b) For purposes of computing the timeliness of payments, the insurer shall be deemed to have received a bill and report 3 days after mailing by the provider. Payments shall be deemed timely made if mailed on or before the 30th day following receipt of the bill and report.

(c) If an insurer requests additional information or records from a provider, the request may not lengthen the 30-day period in which payment shall be made to the provider.

(d) If an insurer proposes to change a provider's codes, the time required to give the provider the opportunity to discuss the proposed changes may not lengthen the 30-day period in which payment shall be made to the provider.

(e) The 30-day period in which payment shall be made to the provider may be tolled only if review of the reasonableness or necessity of the treatment is requested during the 30-day period under the UR provisions of Subchapter C (relating to medical treatment review). The insurer's right to suspend payments shall

continue throughout the UR process. The insurer's right to suspend payment shall further continue beyond the UR process to a proceeding before a workers' compensation judge, unless there is a UR determination made that the treatment is reasonable and necessary.

(f) The nonpayment to providers within 30 days shall only apply to that particular treatment or portion thereof in dispute. If a portion of the treatment is not in dispute, payment shall be made within 30 days.

(g) If a URO determines that medical treatment is reasonable or necessary, the insurer shall pay for the treatment. Filing a petition for review before a workers' compensation judge, does not further suspend the obligation to pay for the treatment once there has been a determination that the treatment is reasonable or necessary. If it is finally determined that the treatment was not reasonable or necessary, and the insurer paid for the treatment in accordance with this chapter, the insurer may seek reimbursement from the Supersedeas Fund under section 443(a) of the act (77 P.S. § 999(a)).